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ABSTRACT

This document contains testimony of witnesses in a field hearing on the future of the rural elderly. The opening statement by Representative Bob Whittaker (Kansas) notes that the aging of America creates a more difficult time for the rural elderly than their urban neighbors. Distance and low population density magnify the difficulties of inadequate medical care, low retirement income, and lack of transportation. Speakers discuss a volunteer network of services for the elderly, shared housing alternatives, types of group therapy, senior citizens law projects, and home nursing services. One speaker describes good accounting practices for transportation which allow multi-funded systems to meet financial reporting requirements of human service agencies purchasing rides. Problems of health care and mental health care delivery to the rural elderly are particularly prevalent. Problems include health manpower, support for family practice residency training, the high cost of medical education, the plight of rural hospitals, fee differentials under Medicare, and medical liability issues. A program that enlists the help of school nurses and counselors, public health nurses, and social workers as part time mental health workers in order to provide more manpower without additional budget is described. This document includes testimony by Monda Spool, director of North Central/Flint Hill Area Agency on Aging in Manhattan, Kansas; Karen Olson, president of Combinations, Inc. in St. Louis, Missouri; Ron Beane from the Department of Elder Affairs, Des Moines, Iowa; Debbie Ford of Beverly Enterprises in Hot Springs, Arkansas; Pat Donahue from Kansas Legal Services, Inc. in Topeka; Joan Remmers, a registered nurse from Sabetha, Kansas; Dr. Ernie Chaney from the University of Kansas School of Medicine-Wichita; and Art Spies, administrative director of the National Institute for Rural Health Policy in Des Moines, Iowa. An appendix includes additional material from Linda Reinhardt, chairman of the Women's Committee, Kansas State Farm Bureau; and Dr. H. Ivor Jones of Shawnee Missouri, Kansas. (DHP)

ED309898

FUTURE OF THE RURAL ELDERLY

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

JUNE 13, 1988, PITTSBURG, KANSAS

Comm. Pub. No. 100-690

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FUTURE OF THE RURAL ELDERLY

MONDAY, JUNE 13, 1988

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1:30 p.m., McCray Hall, Pittsburg State University, Pittsburg, Kansas, Hon. Bob Whittaker (acting chairman of the committee) presiding.

Members present: Representatives Whittaker and Meyers.

Staff present: Linda Vander Velde, Kaye M. Drahozal, Ted Kimble, Mary Meriwether and Irene Whitlock.

OPENING STATEMENT OF REPRESENTATIVE BOB WHITTAKER

Mr. WHITTAKER. Ladies and gentlemen, I would like to welcome everybody here to the hearing. At this time, I would like to recognize the congressional staff who are here from various offices, to participate and to gain information.

I would like to introduce Robyn Henderson of Senator Exon's office in Washington; D. D. Lemmond from Senator Dole's office in Parsons; Rose Mary Mong from Senator Dole's office in Topeka, and Carolyn Williams from Senator Kassebaum's office in Wichita.

And, then, on my staff, I would like to very briefly introduce Linda Vander Velde of my Emporia office, Kaye Drahozal of my Washington office. They have been primarily responsible for assisting with the conference.

Also, Ted Kimble, Mary Meriwether and Irene Whitlock of my office.

Ladies and gentlemen, I would like to thank the Select Committee on Aging for granting this field hearing on the Future of the Rural Elderly.

America is, indeed, aging. This graying of America is one of the most significant demographic facts affecting us today and well into the future.

The first few decades of the 21st Century will see the total number of persons over 65-years old double in size. By the year 2030, the number of people over 65 will at least quadruple.

While all this shift in demographics affects our whole country, its effect is being felt even more strongly in our smaller towns and rural areas. The elderly, wherever they live, share the common problems of growing older, but those living in the rural areas report a much more difficult time coping with the problems than their urban neighbors.

Why many of these problems center around the geographical location and the lack of access is what we want to explore. Distance

and low population density magnify the difficulties of inadequate medical care, low retirement income and lack of transportation.

But rural America, ladies and gentlemen, has a tremendous and often unrecognized resource. Rural Americans have a strong network of family, church and friends that is unparalleled.

This network can provide the needed link between being isolated and being a part of the community.

Ladies and gentlemen, there is much reason for hope.

Today, we have gathered before us people who are involved in the day-to-day provision of services to the elderly, who will be expressing their vision of the elderly in rural America. These people come from many different areas, including housing, transportation, health services. Yet, they share the common goal of providing services in the best way possible, to a segment of our population that is gaining in leaps and bounds.

[The prepared statement of Representative Whittaker follows:]

PREPARED STATEMENT OF REPRESENTATIVE BOB WHITTAKER

I WOULD LIKE TO THANK THE SELECT COMMITTEE ON AGING FOR GRANTING THIS FIELD HEARING ON THE FUTURE OF THE RURAL ELDERLY.

AMERICA IS AGING. THIS GRAYING OF AMERICA IS ONE OF THE MOST SIGNIFICANT DEMOGRAPHIC FACTS AFFECTING US TODAY AND INTO THE FUTURE.

THE FIRST FEW DECADES OF THE 21st CENTURY WILL SEE THE TOTAL NUMBER OF PERSONS OVER 65 YEARS OLD DOUBLE IN SIZE. BY THE YEAR 2030, THE NUMBER OF PEOPLE OVER AGE 85 WILL AT LEAST QUADRUPLE!

WHILE THIS SHIFT IN DEMOGRAPHICS AFFECTS OUR WHOLE COUNTRY, ITS EFFECT IS BEING FELT EVEN MORE STRONGLY IN OUR SMALL TOWNS AND RURAL AREAS. THE ELDERLY -- WHEREVER THEY LIVE -- SHARE THE COMMON PROBLEMS OF GROWING OLDER. BUT THOSE LIVING IN RURAL AREAS REPORT A MORE DIFFICULT TIME COPING WITH THESE PROBLEMS THAN THEIR URBAN NEIGHBORS.

MANY OF THESE PROBLEMS CENTER AROUND GEOGRAPHIC ISOLATION AND THE LACK OF ACCESS THAT USUALLY RESULTS. DISTANCE AND LOW POPULATION DENSITY MAGNIFY THE DIFFICULTIES OF INADEQUATE MEDICAL CARE, LOW RETIREMENT INCOME, LACK OF TRANSPORTATION, AND POOR HOUSING.

WHEN WE THINK OF THE GEOGRAPHY OF THE ELDERLY, WE OFTEN THINK OF FLORIDA OR ARIZONA...RETIRING IN A WARM CLIMATE. BUT THAT PICTURE OF SENIOR CITIZENS IS MISLEADING. KANSAS RANKS TENTH IN THE COUNTRY IN ITS PERCENTAGE OF PEOPLE OVER 65 YEARS OLD. ARKANSAS RANKS 3rd; IOWA, 5th; MISSOURI, 7th; NEBRASKA, 8th; AND OKLAHOMA, 21st.

EVEN THOUGH MANY OF OUR AREA'S ELDERLY DID MOVE SOUTH SEVERAL YEARS AGO, WE ARE BEGINNING TO SEE WHAT DEMOGRAPHERS CALL "COUNTER-MIGRATION." THOSE PEOPLE WHO WENT TO WARMER PLACES IN THEIR EARLY RETIREMENT YEARS TO LIVE OUT THE REST OF THEIR LIVES ARE MOVING BACK HOME TO BE CLOSER TO FAMILIES AND LIFE-LONG FRIENDS. MANY OF THEM ARE MOVING BACK TO OUR RURAL AREAS. APPARENTLY, THE GRASS IS NOT ALWAYS GREENER ON THE OTHER SIDE OF THE COUNTRY!

THIS CHANGE IN DEMOGRAPHICS IMPACTS ALL SERVICE AREAS. HEALTH CARE AND THE DELIVERY OF HEALTH SERVICES IMMEDIATELY COMES TO MIND. CERTAINLY HEALTH CARE IS AN IMPORTANT CONCERN FOR THE ELDERLY AND THERE ARE A NUMBER OF UNIQUE PROBLEMS IN RURAL HEALTH CARE THAT WILL INTENSIFY OVER THE NEXT DECADES IF THEY ARE NOT ADDRESSED IN A MEANINGFUL WAY IN THE NEAR FUTURE.

BUT GROWING OLD IN RURAL AMERICA MEANS MORE THAN HEALTH CARE. TRANSPORTATION CONTINUES TO BE A MAJOR BARRIER FACING THE RURAL ELDERLY. A 1984 REPORT PUBLISHED BY THE SENATE SPECIAL COMMITTEE ON AGING ESTIMATES THAT BETWEEN 7 AND 9 MILLION RURAL ELDERLY LACK ADEQUATE TRANSPORTATION.

THIS MEANS MUCH MORE TO THEM THAN JUST NOT BEING ABLE TO GET AROUND LIKE THEY USED TO. IT MEANS NOT BEING ABLE TO DO THE THINGS THAT MOST OF US TAKE FOR GRANTED...SEEING FAMILY AND FRIENDS, GOING SHOPPING, VISITING THE DOCTOR, ATTENDING CHURCH, BEING INVOLVED IN THE COMMUNITY.

TAKE AWAY THAT TRANSPORTATION AND YOU TAKE AWAY A VALUABLE LINK BETWEEN THEM AND THE REST OF SOCIETY. IT ALSO MEANS THAT PROGRAMS SET UP SPECIFICALLY FOR THEM -- ADULT EDUCATION, CONGREGATE MEALS, AND HEALTH PROMOTION ACTIVITIES -- ARE UNDER-USED BY THOSE VERY GROUPS THEY ARE MEANT TO TARGET.

THE NEED FOR ADEQUATE HOUSING CONTINUES TO INCREASE FOR OUR RURAL ELDERLY. ALTHOUGH THE ELDERLY ARE MORE LIKELY TO LIVE IN THEIR OWN HOMES THAN THE NON-ELDERLY, THEIR HOMES ARE MORE LIKELY TO BE OLDER AND IN NEED OF REPAIR.

WE ARE TOLD THAT MANY ELDERLY PEOPLE...ESPECIALLY IN RURAL AREAS...LIVE IN HOUSES THAT ARE "TOO BIG" FOR THEIR NEEDS AND TOO EXPENSIVE FOR THEM TO MAINTAIN. BUT WHAT OPTIONS ARE THERE? RURAL AREAS GENERALLY LACK THE ALTERNATIVES FOUND IN URBAN AREAS. IN RURAL AMERICA, IT IS EITHER YOUR HOME OR A NURSING HOME, WITH LITTLE CHOICE IN-BETWEEN.

BUT RURAL AMERICA HAS A TREMENDOUS, IF OFTEN UNRECOGNIZED, RESOURCE. RURAL AMERICANS HAVE A STRONG NETWORK OF FAMILY, CHURCH, AND FRIENDS THAT IS UNPARALLED. THIS NETWORK CAN PROVIDE THE NEEDED LINK BETWEEN BEING ISOLATED AND BEING A PART OF THE COMMUNITY.

THERE IS MUCH REASON FOR HOPE. TODAY WE HAVE GATHERED BEFORE US PEOPLE WHO ARE INVOLVED IN THE DAY TO DAY PROVISION OF SERVICES TO THE ELDERLY, WHO WILL BE EXPRESSING THEIR VISION OF THE ELDERLY IN RURAL AMERICA. THESE PEOPLE COME FROM MANY DIFFERENT AREAS...HOUSING, TRANSPORTATION, HEALTH SERVICES...YET THEY SHARE THE COMMON GOAL OF PROVIDING SERVICES IN THE BEST WAY POSSIBLE TO A SEGMENT OF OUR POPULATION THAT IS GAINING IN LEAPS AND BOUNDS.

Mr. WHITTAKER. At this time, I would like to call on my esteemed colleague and personal friend from the Kansas delegation. She is very much responsible for this hearing, being on the Select Committee on Aging. I would like to welcome my colleague, Congresswoman Jan Meyers, for an opening statement.

Ms. MEYERS. Thank you, Bob.

STATEMENT OF REPRESENTATIVE JAN MEYERS

Ms. MEYERS. Thank you.

One of the most urgent needs—can you all hear in the back there? Does this microphone carry well enough?

One of the most urgent needs facing Kansas and the Nation is rural health care. As a Kansan, as a member of the House Select Committee on Aging, as a concerned citizen, as a friend of Bob Whittaker's, it is really a privilege to be here today to address this vital issue, and it is especially appropriate to be talking about rural health care here in Kansas, rather than in Washington, D.C., and that was one reason why I was pleased to be able to work with Bob and get this Select Committee hearing here.

I think it is fair to say that there is a heightened awareness in Congress of the problems associated with rural health care. Transportation, availability of services, costs, Medicare reimbursement rates, availability of doctors and nurses.

As many of you know, the week of May 15th was declared National Rural Health Awareness Week, and the resolution states a number of interesting things. That Rural Americans account for nearly 25 percent of the population, but are served by only 12 percent of the Nation's doctors, 18 percent of the Nation's nurses, and 14 percent of the Nation's pharmacies.

The resulting health status of rural Americans remains significantly lower than that of urban Americans with rural Americans showing a disproportionately higher rate of maternal and infant mortality, injury and chronic illness.

Accessibility to the available health care services in rural America is limited, not only by the lack of transportation, but also by the fact that more rural residents are uninsured.

Closures of rural hospitals and other health care facilities which have a severe impact on their communities continue to spread across the rural areas of the Nation.

Furthermore, several important provisions were included in the budget reconciliation bill for fiscal year 1988. That is the one that we passed last December for fiscal year 1988.

First, the bill authorized grants to assist small rural hospitals and their communities in the planning and implementation of projects, to modify the type and extent of services that the hospitals provide in order to adjust to the various changes in their populations.

This planning could involve changes in service population, clinical practice patterns, demand for acute care in-patient hospital capacity, ability to provide appropriate staffing for in-patient hospitals, demand for ambulatory and emergency services, demand for appropriate integration of community health services.

The President recommended funding for this program in fiscal year 1989. The Appropriations Subcommittee on Health has yet to report its recommendations. We should know what that recommendation is from that Appropriations Committee in a few weeks.

The reconciliation bill created an Office of Rural Health Policy within the Department of Health and Human Services. Its charge is to coordinate all rural health care issues and be a voice for further reforms and innovative approaches. It should be a real advocate for rural America.

A position in a rural health care manpower shortage area will get an additional 5 percent repayment in addition to the Medicare repayment. It also increased the reimbursement for rural health clinics from $32.10 per visit maximum to $46 per visit.

Furthermore, it said that psychologist services in rural mental health clinics are made reimbursable and direct reimbursement is authorized for psychologist services furnished at community mental health centers.

Another important provision requires peer review organizations to take into account special problems associated with delivering care in more remote rural areas. The availability of alternatives to hospitalization and distance from a patient's residence to the site of care.

These are important steps, but the effort must continue. I am sure that you are all aware that just this last week, the House passed the Catastrophic Care Bill. The Senate approved the Conference Report on Catastrophic Care. The Senate has approved the report, and I am sure the President will sign it if he has not signed the bill already.

This provides not only additional care in hospitals for the elderly, but also provides for pharmaceutical drugs after a certain deductible, and I think will give the elderly, both rural and urban, in this country a great deal of peace of mind.

If other constituencies are like mine, they probably would have preferred that we address the long-term care issue first and the catastrophic issue second, but that is not the way that it worked.

But that is not the way that it came before us. I voted against the Catastrophic Bill when it was before the House the first time for that very reason, because I did want to address long-term care first.

But I did not win that one. Catastrophic Care was before us. I think it was in pretty good shape when it came back from the Senate in conference form, and, so, I did vote yes the second time.

I look forward to hearing what our conferees have to say today.

Thank you very much for asking me to be with you.

Mr. WHITTAKER. Thank you, Congresswoman Meyers.

At this time, ladies and gentlemen, we are going to call our first of three panels of witnesses. Because of the diversity of material that we need to cover and the need to conclude sharply at 3:30, we are going to have to follow a very rigid schedule of allowing each of the participants 5 minutes. This will allow us some time for questions.

There are also a couple of folks who had additional material that they would like to present today.

If we have time, and if we are able to stay on schedule, I would like to give Linda Reinhart from the Kansas Farm Bureau and Jim Garrison from Southeast Kansas Community Action an opportunity to present their material. If we cannot, we will have a place in the record for them to present whatever testimony they might want.

So, with the first panel, I would like to call before us now Monda Spool, Director of the North Central/Flint Hill Area Agency on Aging from Manhattan, Kansas; Karen Olson, Combinations, Incorporated, Olivette, Missouri; and Ron Beane, Department of Elder Affairs, Des Moines, Iowa.

Thank you, ladies and gentlemen, for being here.

Monda, why do we not start with you?

STATEMENT OF MONDA SPOOL, DIRECTOR, NORTH CENTRAL/FLINT HILL AREA AGENCY ON AGING, MANHATTAN, KANSAS

Ms. SPOOL. The North Central/Flint Hill Area Agency on Aging serves an 18-county community comprised of approximately 54,000 persons age 60 years of age or older.

These individuals live in varying degrees of independence, from total independence with the ability to perform adequately daily living tasks to total dependency, unable to perform even the simplest of tasks for daily living.

The aged population is dispersed throughout a predominantly rural geographic region comprising approximately 20 percent of the state land area.

Access to services for these rural residents is affected by primarily three factors. A means to access, such as transportation. Knowledge to access, knowing what services are out there and how to apply for those services. And the availability of the service network to meet the needs.

Types of services that are available to the rural elderly vary in the degree of sophistication provided and in the frequency of services being available.

For these reasons, the linkages between and among care service providers becomes a crucial element in the effective and efficient delivery of adequate services.

The Area Agency on Aging has used innovative linkage solutions. The North Central/Flint Hills Area Agency uses 41 nutritional sites as focal community access points. This network enables elders at the community level to access assistance.

In addition, the Community Services for Aging Program, a direct service program provided by the Area Agency, provides a similar service linkage to core groups of 115 senior volunteers. This volunteer network provides assistance to older persons attempting to access services. These volunteers directly link the older person to the helping professional. They serve as peer counselors and perform outreach activities to expand community knowledge of available services.

The Area Agency also publishes a regional newspaper reaching currently well over 17,500 older persons. Readers are provided with current information on what types of services are available and what current legislative issues are affecting their lives.

In fiscal year 1988, from October 1st until April 30th, 887 CSA participants sought such service linkage. The types of requests that are received were broken into categories of general aging services, public benefits, consumer issues, nursing homes, legal and an array of miscellaneous types of health service assistance.

Twenty-two percent of those that requested for information needed information on transportation. Twenty-five percent of the individuals needed help with energy assistance. Forty-one percent made requests related to insurance, filling out claim forms, what type of benefits were available to them.

The CSA program is but one method existing at the local level to aid rural residents access programs and services.

Another innovative program is the RURAL ACCESS project, which is a special activity sponsored by the Area Agency and we are the administrating agency.

It is an example of a cooperative effort among the North Central/Flint Hills AAA and 15 other agencies in Riley County. The 17-month project focuses on developing a computerized directory of pertinent services for the county's elderly citizens and in disseminating information concerning the Riley County.

The message that we are trying to impart is that within the use of one phone call, the general public can be linked to what is available in Riley County and in the City of Manhattan. The directory itself will be computerized on a data bank.

Each agency is working in cooperation to not only provide general service information, but also to attempt to coordinate other types of help that the elderly require.

The last example that I would like to give is the Glen Elder Work Connection, which serves as an example of providing in-home needs, such as a handyman and chore services, in a very rural elder of our service area.

Job seekers participate in this low-cost new program by providing information on their skills and work experience. Mowing, window cleaning, cooking, driving and grocery shopping are some of the types of things these workers can do.

The available workers are listed at our nutrition sites, on the Senior Center bulletin board and also in a monthly newsletter. The center staff links the senior to the worker. This program so far has cost our agency approximately $900. The program, which has been effective and also fairly inexpensive, is a direct result of taking current personnel costs and pooling those costs so that we can be innovative in this effort.

In conclusion, I would like to say that the needs of rural elders do not vary that much from their urban counterparts. The methods used to link and coordinate aging services in a rural community are as diverse as the types of communities which span our great State.

Coordination, effective linkage systems, and cost containment are the components necessary to build those systems which serve the old.

Thank you.

[The prepared statement of Ms. Spool follows:]

PREPARED STATEMENT OF MONDA SPOOL

The North Central-Flint Hills Area Agency on Aging services an 18-county community comprised of approximately 54,000 persons age 60 years of age or older. These individuals live in varying degrees of independence from total independence with the ability to perform adequately daily living tasks to total dependency unable to perform even the simplest of daily living tasks. The aged population is dispersed throughout a predominately rural geogaphic region comprising approximately 20 percent of the state land area.

Access to services for these rural residents is affected by the primary factors of: 1) means to access, i.e., transportation; 2) knowledge to access; and 3) service network available to meet the need. Types of services available to the rural elderly vary in the degree of sophistication provided and in the frequency of service availability. As an example, medical facilities housed in Salina service adjoining counties where such facilities are not available. The physical facility location limits the frequency of services available to the surrounding communities. The North Central-Flint Hills Area Agency on Aging directly provides nutrition, community services, employment, and Keynotes, a regional newspaper to the community. The agency contracts on the local level to purchase in-home services, accessing services, and to support senior facilities. Mental health, income maintenance, medical and housing services are typical types of local services available in a rural area.

Linkages between and among service providers become a crucial element for the effective and efficient delivery of adequate services.

Problems which arise as elders seek assistance vary from inadequate services existing on the local level to lack of knowledge for identifying sources of help. Coordination difficulties also, add to the problem. Sheer geographic distance to service providers' facilities also contributes to difficulties associated with receiving needed services. Lastly, the additional unit cost increases in a

rural setting by virtue of geography, numbers served in sparsely populated regions and overall operational service delivery costs.

Formal/informal service providers exist in varying degrees throughout a rural region. Often times, there is a genuine lack of formal service providers to meet the multiple needs of the aged. Where formal structure exists multiple service functions fall to a single organization out of necessity to provide this help. Due to costs and limited availability of resources the multiple-function organization can more adequately address service needs. These rural organizations through pooling of resources, professional talent, and cost sharing can provide an adequate level of community services.

The Area Agency has used innovative linkage solutions. The North Central-Flint Hills Area Agency on Aging uses 41 nutritional sites as focal community access points. This network enables elders at the community level access assistance. In addition, the Community Services for Aging program (CSA), a direct service program sponsored by the Area Agency, provides service linkage through a core group of 115 volunteers. The volunteer network provides assistance to older persons attempting to access services. These volunteers directly link the older person to the helping professional, serve as peer counselors, and perform outreach activities to expand community knowledge of available services. The Area Agency publishes a regional newspaper reaching approximately 17,500 elderly persons as another technique to improve service accessability. Readers are provided with current information on services available and on how to access these services.

For Fiscal Year 1988 during the period October 1, 1987 to April 30, 1988, 887 CSA participants sought service linkage. The types of requests received were categorized into aging services, public benefits, consumer, nursing home, legal and miscellaneous. Twenty-two percent were requests for transportation, 25 percent were requests for energy assistance, and 41 percent were requests

for insurance assistance, i.e., filing for benefits. The CSA program is but one method existing at the local community level to aid rural residents access programs and services. CSA interfaces on a regular and frequent basis with local providers to coordinate assistance provided to the elderly population.

The RURAL ACCESS project is another example of a cooperative effort among the North Central-Flint Hills Area Agency on Aging and fifteen other agencies, hospitals, nursing homes, etc., in Riley County. The seventeen month project focuses on developing a computerized directory of pertinent services for the county's elderly citizens and in disseminating information concerning the directory to the elderly through various outreach activities.

Accessing the directory may be accomplished easily, with one phone call, however; public awareness of the directory will require other outreach efforts. Aside from publicity, the project includes the gatekeeper program where community service people may learn about the directory and disseminate that information to their clients. Participating agencies in the grant may also pass along news of the directory through their involvement in caregiver trainings provided by the grant, and through agency newsletters, and other word-of-mouth activities.

The directory itself incorporates a comprehensive listing of services for the elderly ranging from those provided by formally organized agencies to informal services provided by volunteers or other individuals. The directory will provide a one-stop way the elderly and their families/caregivers may obtain information on services currently available to the elderly. The directory will also contain valuable information on many services previously known only to a limited number of human service staff. Computerizing this type of information is contingent on each agency's willingness to contribute toward a cause which will not only help the elderly live more independent lives but will assist agencies in more effectively meeting the needs of the elderly in our county.

Successfully building the entire system requires participation, support,

and a common understanding of the project's goals from all agencies involved. Early in the project, the Project Coordinator met with each agency's administrator and project representatives to review the project, foster a sense of teamwork, and stress the mutual benefits each agency will receive from the project. Since then, the Project Coordinator and the Project Director have met monthly with the sub-contractors of the grant, followed by monthly meetings among all participating agencies.

To facilitate a cooperative spirit agencies have been encouraged to join in group decision-making on various aspects of the grant. Although at times this has delayed completion of a few data related components of the grant, it has also increased agencies' interest in the project and a desire to "see it through." The project often addresses certain matters of "turf" and, therefore, it is extremely important that agencies are given the opportunity to express their interests and participate in the decision-making process. It is hoped at the completion of this project that a computerized information and referral accessing tool will be in place.

Glen Elder Work Connection serves as an example of service linkages to meet in-home needs for handyman and chore services. Job seekers participating in this low-cost new program provide information on skills and work experience. Mowing, window cleaning, cooking, driving and grocery shopping services are provided by these workers. Available workers are listed on a Senior Center bulletin board and monthly newsletter. The center staff links the senior to the worker. Six month budget to fund this service was $900. The program was coordinated with other services being provided by center personnel which reduced the costs for the Work Connection Program.

Conclusion

The needs of rural elders do not vary from those of their urban counterpart. The methods used to link and coordinate aging services in a rural community are as diverse as the types of communities which exist across rural Kansas. Coordination, effective linkage systems, and cost containment are the components necessary to build those systems which serve the old.

Mr. WHITTAKER. Thank you, Monda.

I would comment that for the future panelists, we do have a young lady here at the front that will indicate for you how much you run over and when we really need you to kind of wrap it up.

We will place your entire testimony into the record.

Our next speaker is Karen Olson of Combinations, Incorporated, from Olivette, Missouri.

Welcome, Karen.

STATEMENT OF KAREN OLSON, PRESIDENT, COMBINATIONS, INCORPORATED, ST. LOUIS, MO.

Ms. OLSON. I am Karen Olson, President of Combinations, Incorporated, from St. Louis, Missouri.

Our company provides shared housing alternatives for companionship or financial and personal assistance based on compatibility matching. We also offer pre-evaluated rental referrals and caretaker services for vacant homes awaiting sale.

Distinguished members of this hearing, I thank you for the opportunity to present the testimony here today.

As required, I have submitted to the committee a written overview of certain aspects of housing for the rural elderly. I hope your busy schedules will allow you to look at the individual and specific points that were made in that overview.

The elderly often think in terms of either remaining in the home in which they spent their mature years or relocating to a retirement community somewhere in a warmer climate. But, in fact, people seldom die in the home in which they have lived and moving South often is beyond their health or their pocketbooks.

The vast majority will have to consider a variety of other arrangements and experience much change. We need more housing options available, particularly for the early interim basis of retirement, and we need more public retirement counseling to prepare our elder population and their families to recognize and confront and work through the need for change.

If they can work through this important time in their lives, they will be able to make good decisions when the time comes, rather than making hasty ones under the pressure of a crisis.

I would like to share with you two typical situations we have encountered during our home sharing activities in Combinations. They particularly address the elderly housing needs. Both show how much change can be required in the rural aged. Each will show how home sharing reduced the number of changes or allowed people to retain their independence longer.

In the first, it is an 85-year old woman who came to us seeking a home sharer to live with her in a retirement hotel. The son, himself a retired farmer had relocated to a one-bedroom condominium and could not take care of the mother. She had moved from the farm years ago to an apartment in town, and as she became more frail and could no longer drive, she then moved to the retirement hotel in the city close to public transportation.

While there, she fell and broke a hip, necessitating hospitalization followed by a period in a nursing home, and then a boarding home before going back to the retirement hotel.

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This is the point at which they came to us to find a home sharer willing to give her assistance and make it possible for her to return to the apartment hotel. Some time later, she needed additional surgery which put her back in the hospital and then again to the nursing home. She died there at 89. Eight major changes in 5 years.

The second situation involves two elderly women for home sharing. One of them was living in a rural setting. Lena Rose was 64-years old. She had recently nursed her husband through a terminal illness. This catastrophic illness had wiped them out financially. She had to sell both her house and her car.

She had come to St. Louis to live with her son. After a couple of months of her grandson sleeping on the couch to accommodate her and a couple of arguments with her daughter-in-law, she came to Combinations.

After a thorough interview, checking five references and a credit check, we began to search for appropriate home sharing situation for her. We advertised in daily and monthly publications. Finally, we found the right person through a referral from a social worker.

She was Helen Green, a 77-year old woman with a small two-bedroom house and one and a half acres in the country, who had only a small pension and was finding utility bills hard to meet. She was also having difficulty maintaining both her house and her garden, a necessity to keep her food costs down.

Lena loved the house and was an excellent cook. She paid for one half of the utilities and any food purchased. They had individual hobbies but shared interests. One of them said, "What a good way to end a fruitful life."

These two histories show how home sharing generates living solutions that are not usually available to the rural elderly.

In contrast to a person living with relatives, despite the family ties, it is not always a good or possible arrangement. And in contrast to the institutional situation designed for large numbers of people, home sharing utilizes the matching skills of a caring professional to provide the potential for the development of a real friendship and a pooling of resources with a minimum amount of change.

I would also like to make a couple of comments about two other early interim housing solutions. The co-op is another form of house sharing. This arrangement reduces the responsibility for a person caring for the home to provide a homelike atmosphere, companionship, security, and self-determination within a group, but not in a non-institutional setting, and is appropriate for both singles and couples.

Selectives. This is a housing solution that keeps the older person within their community so as to avoid some of the problems of breaking ties with their existing support network and because of the smaller size of the planned retirement community, its residents remain blended in the community as a whole and do not experience the isolation of aged limitations. It is also appropriate for both singles and couples.

Thank you.

[The prepared statement of Ms. Olson follows:]

COMBINATIONS INCORPORATED

WHERE LIVING SOLUTIONS COME TOGETHER

TESTIMONY BEFORE THE HOUSE SELECT COMMITTEE ON AGING
Hearing at Pittsburg, Kansas
June 13, 1988

Testimony by Karen Olson,
President, Combinations, Inc.

9378 OLIVE STREET ROAD ■ OLIVETTE, MISSOURI 63132 ■ 314 997 3970

Testimony by Karen Olson,
President, Combinations, Inc.
St. Louis, Missouri

Combinations, Inc. is a company that provides shared housing alternatives for companionship or financial and personal assistance, based on compatibility matching. It also offers pre-evaluated rental referrals and caretaker services for vacant homes awaiting sale.

BRIEF OVERVIEW OF THE HOUSING PROBLEM OF THE AGING

The housing problem of the aged is enormous:

-- In 1985, the elderly numbered 28 million (12% of the United States population).

-- Since 1900, life expectancy in the United States has increased 30 years (males, 71; females, 78).

-- In 1985, 30% (8.1 million) of all non-institutionalized older persons lived alone.

-- When people retire, they do not typically move. Older people prefer to make adjustments within the home they already occupy or at least in their local environments. (Leo Baldwin, Coordinator, Housing Programs, American Association of Retired Persons.)

A clear picture emerges: the need is enormous; the elderly need to be aware of all their housing options; alternative housing programs should exist that will help them remain in their homes or at least continue to actively live in their home communities; and the community should be prepared to assist in housing transitions.

HOUSING SOLUTIONS OFFERED BY COMBINATIONS, INC

Combinations, Inc. provides four divisions that service the housing needs of the elderly in a variety of ways. Since opening in 1984, it has served over 4000 older and younger applicants with an overall 95% success rate.

Combinations meets the great need for interim housing among the elderly, who may not be ready for institutional housing. We procure conveniently sized and equipped apartments or houses or homesharing companions to provide for income and/or companionship and services. For people moving to smaller quarters we provide caretaker service for their vacant home until it is sold.

Homesharing helps to fulfil the 3-part recipe for elderly happiness: good health, economic security, and viable companionship. It lessens loneliness and anxiety and provides built-in friendship. There are several homesharing options. Two elderly people may share only household expenses and chores. An elderly person needing more attention may have their needs met by a homesharer who pre-agrees to the assistance to be given: from cooking and cleaning to errands, transportation, or non-professional care for the disabled. The sharer may receive rent-free accommodation or a small allowance. The sharer becomes a part of the household, not an employee.

Combinations' homesharing processing includes:

1) Compatibility screening of both parties to a match, including personal interviews (at office or home) to discover likes, dislikes, interest, attitudes, needs. Refrences are checked; credit checks are made. Compatibility screening requires considerable experience and expertise to provide candidates suitable to a range of situations. It is the key element to the success of a match.
2) Writing and inserting line advertising in local publications, handling all correspondence, and maintaining confidentiality.
3) Coordinating all contacts and appointments between applicants.
4) Providing a 30-day trial period, during which the match is tested. Should any irresolvable problems occur, the search is reinstituted at no extra cost.

As Combinations, Inc. has operated out of one urban location, our service has been geographically limited to urban and suburban needs. But 4 years of experience with Seniors has helped us to identify, adapt to, and cater to the needs of the elderly in general, providing us knowledge and skills that can be extended to the needs of the rural elderly as well.

PROBLEMS SPECIFIC TO RURAL ELDERLY

1) Medical. The burden on one person (elderly spouse or child) caring for an elderly person can be very taxing. There is often a need for neighbors to monitor the elderly. Medical services are limited or distant. Transportation to medical facilities is difficult. County assistance with medical expenses may leave the elderly to pay for extra costs and equipment rental. Nurse-initiated hygiene may be infrequent and irregular.

2) Transportation. The elderly person who does not drive is very confined and dependent on others. Both shopping and recreation are curtailed. Even those who drive may be housebound by inclement weather.

3) Home maintenance. The elderly find it hard to keep up with home and yard chores. Power cuts may be paralyzing. Amenities may be limited, e.g., possession of only a wood-burning stove that may be too much for one person to keep going.

4) Nutrition and self-maintenance. Often the elderly neglect or are unskilled in the preparation of regular meals. Knowledge of good nutrition may be lacking. Clothing may be neglected, both as to repair and cleanliness.

5) Companionship and recreation. The need for company may be only sporadically met. For the most part social organizations exist in town. Access to recreation (movies, library, senior center, etc.) may be limited by distance or inability to travel.

6) Rental options. Often in rural areas, rental apartments are not nearly as available as in the city. If the elderly cannot continue to handle their own home alone, alternative housing options are fewer than for the city dweller.

7) Control. The elderly often feel a loss of the power to control their own lives (a loss often heightened in a nursing home) and they need encouragement to go on caring for themselves and staying active. Reliance on neighbors and outside friends becomes an imposition. Self-reliance needs to be continually re-affirmed and housing situations must be developed to encourage it.

THE FUTURE OF HOUSING FOR THE RURAL ELDERLY

We offer several suggestions to meet the housing needs of the rural elderly:

A) HOMESHARING

One of the most important keys to solving the elderly's housing problems is single or multiple homesharing. The benefits are obvious: companionship, greater security, lower expenses, and someone there if you need them. It also reduces the financial burden on the State.

The key to homesharing is the matching of people together and a homesharing referral program to accomplish this requires the following components:

1) It must be affordable. Combinations charges a fee of $73 that barely covers the cost of processing and has still had to turn away hundreds that could not afford that minimal fee. A sliding scale would make the program accessible to triple the volume of applicants.

2) Services must be available to everyone. To meet the rural need we propose a referral service with the following features:

   [a] One main metropolitan office that handles local applicants, data storage, and matching processes.

   [b] Satellite offices that have one or two counselors whose responsibilities are to interview applicants and handle the local part of the search. All applicant information is then transferred to the main computer system for storage and retrieval. Since the matching of candidates is a highly skilled endeavor, the central counselors will do this in consultation with the local interviewer. There are two advantages to this system: No local community is wholly dependent on its own local resources, but the familiarity of the local counselors with their community will be fed into the central processing.

   [c] A strong network with social workers and medical professionals.

B) RETIREMENT COUNSELING

There need to be more encompassing retirement counseling programs - not just company sponsored programs but public programs available to the employed and also to the spouses and to the non-employed. The programs that exist now typically address the financial concerns of the elderly. We need programs that are concerned with the human elements: What if I have a stroke? What if my spouse dies - will I be able to maintain my home? What are my options?

C) COMPARATIVE STUDY OF PROGRAMS FOR ELDERLY
An exploratory study of successful programs established in other countries would be valuable. Two examples are:
The cooperative home. In England seniors are sharing large older homes with 8 or more residents. Each person has their own room and assists with household and yard chores. An employed house manager oversees the operation. Each resident pays rent, a portion of the utilities, and for food. In the United States, many smaller communities have large older homes which might be converted into cooperatives to allow rural residents to remain in their general environment. For this type of situation a referral service is almost essential to create a compatible group.
The collective village. Collective villages are used throughout Europe. Collectives are small, informal, semi-planned, community developments in rural settings within a specific geographical area designed for the retired elderly of that area. This allows residents to continue to participate in their social structure: church, grange, etc. The one-storey single family units are built to appeal to older owners with the emphasis on ease of maintenance and ease of activity. These units are situated on at least an acre of land each to allow continued gardening, etc. and to give a sense of space that rural residents are accustomed to. Yard care assistance can be provided on request. Homes can be purchased or rented (the rented units being owned by the collective). Occupants are usually required to pay a small monthly maintenance fee. Since these collectives are less formal than the usual retirement village, fewer restrictions are generally specified. The residents are the decision-making body as to how the collective will function. Some possible options for them are: an employed resident manager; a club house with or without activities; a van to facilitate transportation; a small convenience store.

D) TRIAL PROGRAMS All over the United States various experiments in alternative housing for the elderly are being tried. We need more shared information on these experiments. As is true in other areas, so in housing, programs should be field-tested for quality and effectiveness. More of these tests should be initiated now before the problems of the rural elderly reach a crisis level. By instituting pilot programs with smaller numbers of persons, we can see how well they work and expand them as necessary to meet the increased population of rural senior Americans, who are asking, How and where do I live out my final years? Each project should have a clear system of accountability and assessment built in.

EXISTING OPTIONS

Independent living

(1) Continue to live in own home.
(2) Buy smaller home or condominium.
(3) Rent a house, condominium, or apartment.
(4) Mobile home.
(5) Resort community.

Semi-independent living

(1) Homesharing.
(2) Living in own home and hiring part-time nursing or homemaking professionals.
(3) Living in own home and attending day care centers or day hospitals.
(4) Living in retirement community with or without health and custodial services.
(5) Living in apartment hotel.
(6) Low income and public rental housing.
(7) Retirement apartment houses.
(8) Retirement hotels.
(9) Licensed boarding house where elderly live in protected situations and receive help with daily care given by non-medical staff.
(10) Living with relatives.

Dependent living

(1) Retirement home with health and custodial services.
(2) Licensed board and care homes with professional nursing care.
(3) Intermediate care nursing institutions.
(4) Skilled nursing care institutions.
(5) Hospital.
(6) Hospice.

E) GUIDING PHILOSOPHY

"People come first in every situation." This is the guiding client-oriented philosophy at Combinations, Inc. In designing programs it is easily lost to other concerns but we need to constantly remind ourselves of it. The system must be responsive to the users and adapted to their needs. Too often the elderly have been dealt with with a view to our needs rather than theirs. Available options are not always desirable because moving the elderly from their familiar setting can be a shock that leads to earlier deterioration.

I conclude this testimony with a tribute to this Congressional Committee for its foresight in commencing this dialogue on the possibilities for the future in this important area of the elderly and their needs.

Mr. WHITTAKER. Thank you very much for that excellent statement.

Mr. Ron Beane comes to us from the Department of Elder Affairs in Des Moines, Iowa.

STATEMENT OF RON BEANE, DEPARTMENT OF ELDER AFFAIRS, DES MOINES, IOWA

Mr. BEANE. Congresswoman Meyers and Congressman Whittaker, thank you for this opportunity to share perspectives concerning rural transportation for the elderly.

I am Operations Administrator for the Department of Elder Affairs. As advocates for elders in predominantly rural states, we know that almost every service designed to encourage independence among rural elderly is dependent on the availability of accessible, affordable transportation.

I also am the Chairman of the Transportation Accounting Consortium, a group of 8 states, of Arkansas, Colorado, Florida, Iowa, Massachusetts, Michigan, North Carolina and South Carolina, which was formed 9 years ago to identify and reduce barriers to coordinated transportation, especially in rural areas.

As with the other states represented on each panel, many Iowa seniors are living in rural areas, separated from essential medical, social and shopping services. More than 60 percent of Iowan counties have populations less than 20,000, and 15 percent of our counties have no town with a population over 2,500.

This means that some vital services must be obtained in another county. With Iowa's rapidly growing population over 85 years of age, it is clear that an increasing proportion of our citizens are prevented from driving, either for financial or health reasons.

Fifteen years ago, State agencies in Iowa identified that coordinated transportation systems would provide the most cost effective service delivery to the widest range of constituent groups.

For very good reasons, funding is available from a number of different sources with local decision-making regarding implementation. We believe that the best coordination occurs at the local level, with State and Federal agencies enabling local coordination through capacity building and thoughtful review of requirements for records and reports.

Several aspects of administrative capacity building are being addressed by the Transportation Accounting Consortium, with financial support from the U.S. Department of Health and Human Services and the U.S. Department of Transportation.

The Consortium has issued a manual entitled "Rural Transportation Accounting: A Model Uniform Accounting System for Rural and Specialized Transportation Providers."

This manual promotes good accounting practices for transportation providers which allows multi-funded systems to meet the financial reporting requirements of human service agencies purchasing rides.

Now, the Consortium is developing a training package to assist State and local agencies implement the recommendations. We are ready to help the Rural Technical Assistance Program develop cost allocation and financial management procedures which will further

increase the capacity of rural transportation providers to efficiently meet the service needs of a variety of constituents.

In 1986, the U.S. Department of Transportation and the U.S. Department of Health and Human Services established the Joint Council on Interagency Transportation Coordination to improve management practices, remove Federal barriers to coordination, and disseminate information.

Additional congressional support of these efforts would be particularly helpful at this time. Rural transportation now receives more support from States than from the Federal Government. Federal appropriations can be optimized by increasing flexibility to encourage local coordination.

I appreciate this opportunity to bring these comments to your attention and thank you for your concerns for rural elders who depend on your support of transportation to prevent isolation in their own homes.

Mr. WHITTAKER. Thank you, Ron, for your very excellent statement.

At this time, I would like to call on Congresswoman Meyers for questions.

Ms. MEYERS. I will start with a question for Monda Spool.

You mentioned a computerized directory as an innovative way to create links between service organizations. How are you getting along with that computerized directory? Is it on line yet? How is it working? What happens just mechanically when someone calls your directory or calls on your directory?

Ms. SPOOL. We are pretty much a third of the way—

Ms. MEYERS. You are going to need that mike.

Ms. SPOOL. Can you hear me now?

Ms. MEYERS. Turn it a little more.

Ms. SPOOL. You get reliant on this technology.

We are about a third of the way through and we have developed a directory of different types of services.

In theory, what we are hoping to have then is that elderly person, the main frame at the main computer we use, currently housed in at the senior center, when an elderly person comes into the center, we have already developed the program we are going to be using.

So far, we have been fairly pleased.

Ms. MEYERS. And when do you think it will be completely up and functioning?

Ms. SPOOL. February of next year.

Ms. MEYERS. Thank you.

Well, yes, I do have another question, but I did not want to—

Mr. WHITTAKER. You are doing fine.

Ms. MEYERS. All right. Okay.

How—I guess my next question would be directed to Ron.

The—I just did that to give them their exercise.

The issue of coordination of transportation is of interest to me. When I was in the State senate and Bob also served in the State legislature, we were faced with the problem, and I remember one time I tried to get some additional money in for transportation for the elderly in rural areas, and I was told at the time that there

was probably adequate transportation there. It is just that there was more than they need here and less than they need here.

How are you getting along with that kind of coordination? Do you—have you found the kind of cooperation that you need and is it moving along?

Mr. BEANE. I cannot say that we have perfect coordination by any means. Each of the funding sources that can purchase transportation has its own requirements and many times, there are good reasons for those requirements. For example, Title 19, which can pay for some transportation, is not primarily a transportation provider as we need recordkeeping as part of the requirements.

One of the things we are trying to do is pull some of those requirements together to provide more flexibility on the part of the funding sources to review those requirements to see if all of those requirements are really necessary to allow a single transportation provider to provide transportation, utilizing a number of different funding sources rather than having a different provider for each funding source.

Ms. MEYERS. Thank you.

Karen, do you think that the rural areas have been slower to move in the area of home sharing than urban areas, and is that because maybe there is more distance involved, it is harder to coordinate people, or is that developing as well in rural areas as in urban?

Ms. OLSON. No, it is not. Simply because the resources are nonexistent, and it would not be cost effective to have the type of organization that we are involved in in every small town around the State.

What we are envisioning at the moment is being able to do the satellite offices in the smaller communities with an interviewer there who will be dealing with the rural elderly in that area. That way, the interviewers are cognizant of the life style and also of any resources available, but they will not be totally reliant on the local resources.

We can see that the matching would be done in our central office in the larger communities. That is very, very possible because we are already working with the information from other counselors so that we can address that kind of cooperation.

So, I can see that one of the problems is that we are a private enterprise. We have to charge a fee. We could triple the number of people we can serve if we could work out a sliding scale, something like that.

Ms. MEYERS. Thank you very much.

I appreciate the comments by the panel and have enjoyed hearing you.

Mr. WHITTAKER. Thank you, Congresswoman Meyers.

Karen, since you are by the microphone, let me just start with you. Are the rural elderly as responsive to your programs as the elderly living in urban areas?

Ms. OLSON. Well, we are not working out in the rural areas. But we get calls every day from people from out in the State of Missouri saying, you know, can you help us. Our problem is that we are transplanting somebody from St. Louis into a smaller community and that is quite difficult.

A lot of people just do not want to make that transition. However, once we were out in the State, then we would be caring for people who are living in the general community area, and that would be very effective. We are being approached all the time by people saying we are in desperate need out here. We are just somewhat constrained in what we can do at the moment.

Mr. WHITTAKER. Ron, you mentioned in your testimony that you emphasize decision-making at the local level. Why is this especially important in coordinating transportation services?

Mr. BEANE. Well, I think it is the right way to go about a number of services, particularly transportation, because of the multitude of funding sources that pulling those funding sources together in Washington, for example, would not meet the needs of local aging and other constituents.

The best way is to have those funding sources flexible enough to encourage that coordination at the local level where it can be designed best to meet the needs of the people right there.

Mr. WHITTAKER. I especially appreciate that comment because I know that Jan and I have wrestled with this issue. Frequently we find ourselves testifying on the need for different Federal programs to give local areas some flexibility. They need to be able to choose the services that are needed for that particular area.

In this respect, block grants are more flexible than the cut and dried categorical grants that many in Congress believe are more appropriate to target special programs.

But the difficulty in targeting is often you do not get that flexibility that you may need, especially in rural areas. I appreciate your comments in that regard, Ron.

Could you tell us, Ron, are you aware of services that the elderly are simply missing out on because of lack of access?

Mr. BEANE. We do not have solid statistics on that, but we know that many people in rural areas, for example, are not able to avail themselves of adult day care, a service which has been identified as being very useful.

But there is a need, of course, for transportation to the day care center, and in priority setting for available transportation, that may not be available.

Mr. WHITTAKER. Thank you very much.

Monda, what role do informal service providers and volunteers play in the rural setting, and how does it differ from in urban areas? Finally, has the role of volunteers made it easier or harder to create the linkages between programs?

Ms. SPOOL. I cannot imagine our Area Agency functioning without the use of volunteers. In our nutrition program, volunteers are an integral part of us being able to deliver our home-delivered meals. We would not have the budget money to provide that service to many in our community.

I mentioned the CSA program, which is built on a program of volunteers. I think it is an integral part of programming. It has done well. They contribute similar to a pay situation, and they also counsel our seniors. So, they are very useful. They contribute respite services that are being provided, and they are far more committed to what is going on in their communities.

I would also like to add, each of our counties have local county councils, which are integral to how we develop our services, and they have input in how we operate our services, and I think those are extremely important in servicing the elderly.

Mr. WHITTAKER. Monda, in many of our rural communities we have some access to a junior college, a community college, or even, in this case, a state university.

What do you see as the role of colleges and universities in creating linkages between our older Americans?

Ms. SPOOL. Well, I think Kansas has been reasonably fortunate in that there is a grant sponsored by an aging dollars, called the WKCSC grant, where the community colleges that work in close cooperation with area agencies to provide training on how elders can interact with politicians.

Their expertise in the area of conducting, training and educating the public is an important part of that grant. Our expertise is that we are actually out in the trenches and providing the services.

So, I think the marriage of those two is important and it has been effective in this State.

Mr. WHITTAKER. Thank you, Monda, and thank you, panelists. You have been very informative.

The next panel that we will have will be Debbie Ford of Beverly Enterprises, Pat Donahue of Kansas Legal Services, Topeka, Kansas, and Joan Remmers of Sabetha, Kansas.

Debbie, let us start with you.

STATEMENT OF DEBBIE FORD, BEVERLY ENTERPRISES, HOT SPRINGS, ARKANSAS

Ms. FORD. My name is Debbie Ford, and I am from Hot Springs, Arkansas.

I am employed by Beverly Enterprises, Incorporated, the largest long-term care organization in America. Our company operates approximately 1,050 nursing homes throughout the United States. I have been employed by Beverly Enterprises for ten years in various capacities.

I currently work as a social rehabilitation consultant, where I consult with 45 nursing homes in Arkansas.

A few years ago, while working in a facility in North Arkansas, an elderly woman approached me and said, "I'm so lonely. I'm so lonely I could die. My husband died several years ago and now I'm all alone. No one seems to care."

Such is the plight of many of our rural elderly in the United States today. I left this woman with a renewed commitment of researching and promoting a way of successfully meeting the social and emotional needs of others like her.

The Census Bureau reports that the 75 plus and 85 plus age groups are the fastest-growing segments of the U.S. population. These groups represent 40 percent of nursing home residents in the United States.

In this area of the United States, the rural elderly represent a vast majority of the nursing home population. It has been estimated that the 85 plus population will more than double in number between 1980 and 2000.

With the increase in the number of rural elderly in this society who are entering nursing homes, the helping professional is faced with the task of identifying innovative ways of meeting the mental health needs of this rapidly-growing population.

In our industrialized society, nursing homes are and will continue to be essential in providing needed care to the frail elderly. Even under the best of circumstances, placement in a nursing home is traumatic and can result in overwhelming fears and anxieties.

Losses that accompany old age and institutionalization can contribute to feelings of helplessness and hopelessness. Depression, isolation, feelings of helplessness and other emotional problems significantly affect the quality of life for the nursing home resident.

Group work is an effective way of meeting the social and emotional needs of the elderly. The objectives of group work include: promoting socialization, ventilation of negative feelings, developing support systems, enhancing self-esteem and turning focus on self.

As one psychologist notes, "Human beings cannot stand alone. The group is not just one aspect of human life, but it is life blood itself, because it represents belonging to humanity."

There are several group approaches that can be used. Examples include reminiscence groups, reality orientation groups, problem solving groups, and new resident adjustment groups. The group that seems to be the most successful with the rural elderly is the reminiscence group.

This group is based on life review, a concept developed by Robert Butler. The rural elderly, having common interests, such as farming, gardening, canning, etc., use this group as a means of communication and developing relationships.

By involving nursing home residents with a group of peers who are experiencing similar problems, the elderly person comes to the realization that he is not alone. We must rely on the strength available to us through peer counseling in a structured group.

With the predicted increase in this population, we do not have the manpower that is needed for meeting social, emotional needs of these residents on an individual basis. Multiple mental health concerns, such as isolation, loneliness and lack of socialization can be addressed in a series of 45 minute group sessions.

In order to be successful, the leader must have a clear understanding of the special characteristics of this population. Educating group leaders is essential in promoting quality group work. Resources must be made available for education.

Group work, used in combination with other treatment programs, has the potential for significantly improving the quality of life.

Over the past 10 years, I have witnessed an increased awareness in the nursing home industry in meeting the psychosocial and emotional needs of residents. However, we must continue as a country to strive to meet those needs.

This can only be accomplished through dedication, perseverance, and a genuine concern for the mental health needs of the elderly.

Mr. WHITTAKER. Thank you very much, Debbie.

I would like to now call on Pat Donahue with the Kansas Legal Services.

STATEMENT OF PAT DONAHUE, KANSAS LEGAL SERVICES, INC., TOPEKA, KANSAS

Mr. DONAHUE. Thank you, Congressman.

Welcome back to Kansas. We are glad to have you back here, both of you.

My name is Pat Donahue, and I coordinate the 11 senior citizen law projects operated by Kansas Legal Services under grants provided by Kansas' 11 Area Agencies on Aging.

The legal service that we provide is the legal service set out to be available for seniors in the Older Americans Act.

Our clients are mostly older people who are poor, and increasingly we are using the law as a tool to untangle peoples' problems with State and Federal programs. By way of example, we recently spent about ten hours over 4 months helping a widow who had received notice of a $12,000 overpayment from the Social Security Administration in her survivor's benefits.

As a result of that overpayment notice, her future benefits were cut off until we legally intervened. After an evidentiary hearing, it was decided that she could receive $5,500 in back pay and not have to pay back any of the $12,000.

The reason for the overpayment was that her husband, who had been married twice, had neglected to tell her about the first marriage.

I would like to give you a little deeper insight into some of the statistics that I think are relevant.

First of all, I think you should know that Kansas is 40 to 50 years ahead of the rest of the United States in aging demographics. We have right now in Kansas 40 counties in which more than 1 out of 5 people will be over the age of 65. The rest of the United States will not get there until about 2030. So, Kansas, in that sense, is a good model to use for developing programs for older people.

There is a higher percentage of elderly in rural Kansas. I compared the Fifth District to nearby Sedgwick County, and on a mean county basis, the percentage of people over the age of 60 in the Fifth District was 24.7. In Wichita right next door, it would be 13.8.

There is a higher percentage of poor people in general of all ages residing in rural areas in Kansas. In your district, 12 percent are poor on a mean county basis as opposed to 9 percent in Sedgwick County.

And there is a higher percentage of poor elderly in rural counties. In the Fifth District again, 14 percent as compared to 10 percent next door in Wichita.

The aging population is growing faster than the younger population. On a 10-year basis, right now, about 7.5 percent of the people over 60 as compared to 4.1 percent for the population at large.

Kansas has experienced a terrific out migration for the past 20 years. It is slowing down somewhat thankfully now. But in the 1980 Census, the U.S. Census Bureau said that 26 counties in Kansas had "high" out-migration. That means in 10 years, they lost 7 percent or more of their population, many in double digits.

Of those 26 counties, 24 were rural counties and only 2 could be considered urban counties. Social security is an important economic base of this State. In 1987, social security made payments to

395,200 recipients in the State of Kansas. That is 16 percent. They received $16.7 billion. And by way of comparison, net income from farming in the State of Kansas was about $1.5 billion.

We have got 19,000 Kansans living as permanent residents in nursing homes. 11,000 of these are on Medicaid. That is over half. The Medicaid program pays about $685 a month for each one of these 11,000.

The rural problems of the rural elderly are intertwined with the problems of rural America, period. The problems are loss of retail markets and jobs. Rural sociologists now talk about the longhorn effect. We have large distribution centers locating in larger communities and this depletes the markets and job availability in the smaller communities.

Agriculture and energy are hard-pressed and not going to bounce back, they are going to crawl back on all fours. Prices are high in rural areas. The crux of the problem is that the young leave seeking opportunity and the elderly stay behind.

The critical question is, as this happens, will high density retirement areas make public policy decisions which promote change, development and community self-sufficiency? If they cannot, they will start a self-perpetuating chain reaction of isolation, stagnation and the result will be a ghost town.

The remedy is stabilization... stop the chain reaction, and the way you can do this is through programs that make sense and programs that are consistent and dependable. We need support but the support should be oriented toward providing what the community cannot provide for itself. For example, technical support, education and health care, and then we need community involvement and local investment. Putting the risk where the benefit is is the best way to ensure effective solutions and ensure quality.

The needs of the rural elderly, as the speaker before me said, are the same as the needs of the urban elderly. There is no great difference there, except they are hard to meet in the case of the rural elderly.

In fact, there is no great change in my mind in what the elderly need since we enacted the Older Americans Act back in 1965. We probably need to do it in a little bit different way. We need to be smarter as we do it, and we are going to need to do more of it.

We need affordable health care. We need affordable nursing home care, housing, transportation, relief from loneliness, in-home services, home health, legal advice and retirement planning, protection from abuse, substitute decision-making for those who can no longer decide for themselves, nutrition projects, and we need employment for those who can and want to work.

The Federal policy should set minimum standards. We should have local implementation and substantial flexibility. We need dependable, consistent policies. We need policies that measure results rather than count numbers.

In the area of long-term care, we need to prevent family impoverishment. We need to apportion the losses and promote economic stability. How do we bend the trend? Well, I ask you, what should your mother and father have in retirement? Then, ask yourself the second question, what should anyone else's mother or father need?

Thank you.

[The prepared statement of Mr. Donahue follows:]

TESTIMONY OF
PATRICK H. DONAHUE
BEFORE
U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON AGING
FIELD HEARING
MONDAY, JUNE 13, 1988
PITTSBURG STATE UNIVERSITY
PITTSBURG, KANSAS

My name is Pat Donahue. I am appearing here a the requests of the House Select Committee on Aging and of Representative Bob Whittaker of the Fifth District of Kansas. I am the Kansas Legal Services, Inc., Coordinator of Senior Citizens Law Projects. Kansas Legal Services provides legal advice and representation to persons over the age of 60 on a state-wide basis and contracts with all 11 Kansas Area Agencies on Aging to provide legal services to senior citizens under the provisions of the Older Americans Act. In 1987 our non-profit law firm provided assistance to 4,232 Kansans over the age of 60. We prioritize our services to those seniors in the greatest social and economic need. These are low-income, homebound, handicapped, isolated minority, and institionalized individuals. We routinely work in support of the Kansas Nursing Home Ombudsman's office and we interface with all social service agencies. I personally represent senior citizen clients everyday. From 1984 to 1987 I served as Chairman of the Kansas Bar Association Committee on Legal Issues Affecting the Elderly. I was asked by the Kansas Legislature to provide technical testimony during the development of Kansas new Division of Assets law and I have testified on other matters affecting older persons, consumers of all ages and children. The senior citizens' cases we typically handle include:

* Low-income wills, probate and estate plans, Powers of

Attorney and Living Wills

* Guardianships and Conservatorships
* Pensions, Social Security and Other Retirement Income
* Medicare, Medicaid and Private Health Care
* Housing
* Consumer, Finance, Insurance
* Adult Abuse
* Nursing Home Matters

General Facts About Seniors in Kansas

First, I would like to give the Special Committee some background information on the elderly in Kansas. In 1986 revised 1980 Census estimated 17.9% (441,000) of all Kansas residents are over 60. Kansas is tied with New York and Maine for twelfth place in the 50 states. The over 60 and over 65 growth rates are 7.0% and 7.7% respectively compared to only 4.1% for our population at large. A report prepared for the Kansas Department on Aging in December 1986, reveals that 33% of the population in Elk county was over the age of 60. There are 8 out of our 105 counties with over 30% of the population over the age of 60. In 22 of our 105 counties, more than one person in ten is over the age of 75. There are more elderly poor than young poor. The 1980 Census showed that 49,472 or 12% of 412,297 Kansans over 60 were below the poverty line. On a state-wide basis 10.1% of the population was below the poverty line. The largest concentration of senior poverty is found in Southeast and in the non-urban Northeast parts of Kansas where over 15% of the persons aged 60 and over are poor. The senior population is predominately female, there being 7 women for every 5 men in the 60+ population. About 52% of the persons 75 and older live alone.

the 60+ group 56% of the women and only 15% of the men live alone. About 4.1% of the elderly population in Kansas can be considered minorities. According to data collected by the Kansas Department on Aging, about 2/3 of the Kansas elderly population can be considered as living in rural areas.

Economic Problems Affecting the Rural Residents of Kansas

In Kansas today, we have a population of 2,450,000 of which approximately 1,200,000 live in rural areas. This is roughly half of the total population. Kansas citizens living in these areas face a number of economic problems:

* Lack of employment opportunity due to shifting of local retail markets in communities of under 10,000 to centralized retail distribution centers in larger communities.
* Declining employment opportunities due to declining fortunes of agriculture and energy industries.
* Out-migration of younger residents who can't afford to stay leaving behind persons with pension and retirement incomes who can stay behind.
* Loss of potential employees and markets which undermines the start-up or expansion of traditional small business.

Evidence of these conditions is easy to find. Banks in rural Kansas continue to fail. There were 8 failures in 1987 and 5 to date in 1988. The Kansas State University Cooperative Extension Service October 1, 1986 Data Source Book on Kansas Demographics points out that there was tremendous out-migration as a part of a national trend in the 1960's. But between 1970 and 1980 Kansas still had out-migration (-0.9%) while other rural areas were recovering. Most of rural western Kansas is still enduring population losses. Population replenishment does occur but when it occurs it is in urban not rural areas. The Salina Journal of May 8, 1988 (pg. 3) noted:

> Farm income declined rapidly between 1979-1985. Average income in the last 5 years was $10,401 (per

family) far short of the almost $18,000 needed to cover family living expenses much less make payments on debt, taxes or purchase machinery.

Despite moderate increases in rural property values in the past year, Kansas land prices remain at approximately 50% of their 1981 values. This net loss of asset value produces corresponding reductions in property tax revenues and this in turn makes it increasingly difficult for smaller communities to finance the infrastructure improvement essential to encouraging business expansion. Residents young and old alike who remain in the smaller rural communities may benefit from lower housing costs but their expenses for durable goods and for a great many services which respond to national, not local, price signals are often higher due to transportation and distribution surcharges.

While I believe that we are heading toward significant improvements in most rural areas, much damage has been done. The young can and do move elsewhere in search of better opportunity. It is the older persons who stay behind.

Remedial Action

I was asked to comment on my views of remedial action. First let me say that I am no expert in rural economics, sociology, community development or macroeconomic planning. But common sense tells me that there is a solution. The ingredients I think are needed are:

1. Stabilization. People in rural areas are able to work with what they have if they can figure out what that will be. Changing federal programs and regulations interrupt sound local planning, eg: The loss of federal revenue sharing dollars has occurred at a very bad time for

struggling communities;

2. Support. Outside help where help is needed, and only where help is needed. Help should target crucial areas like health care, transportation, in-home services, education and technical support.
3. Community Involvement. Communities, given breathing room, can create local economic development which fits the nature of the community and utilizes existing community tangible and intangible resources.
4. Local Investment in Local Business. Invest local support in local projects. This is the best insurance of success. It puts the return and the risk in the same place.

A 1987 Public Broadcasting System documentary Little Towns Like These showed examples of smaller communities that have been successful in protecting themselves against the "ghost town" threat. Three communities showcased were: Red Cloud, Nebraska, Jefferson, Iowa and Oberlin, Kansas. Oberlin is a northwestern Kansas community (pop. 2,387) where local investments by local businessmen working through an economic development group of the local Chamber of Commerce started two successful businesses - a boat manufacturing company and a bus company.

Needs of the Rural Elderly

In my experience the needs of the older urban population and the needs of the older rural population are the same. However, it is more difficult and expensive to construct and maintain systems for the rural elderly than for their counterparts living

in urban areas. In 1965 when Congress adopted the Older Americans Act it identified our national objectives with respect to the needs for our elderly population.

> The Congress hereby finds and declares that, in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our Nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States and of the several States and their political subdivisions to assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives:
>
> 1. An adequate income in retirement in accordance with the American standard of living.
> 2. The best possible physical and mental health which science can make available and without regard to economic status.
> 3. Suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.
> 4. Full restorative services for th se who require institutional care.
> 5. Opportunity for employment with no discriminatory personnel practices because of age.
> 6. Retirement in health, honor, dignity - after years of contribution to the economy.
> 7. Pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities.
> 8. Efficient community services, including access to low-cost transportation, which provide social assistance in a coordinated manner and which are readily available when needed.
> 9. Immediate benefit from proven research knowledge which can sustain and improve health and happiness.
> 10. Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives.
>
> The Older Americans Act of 1965
> 42 USCA Sect. 3001

The Older Americans Act also establishes legal assistance for the elderly as a priority service. I am part of that legal assistance system.

I do not believe that the 1965 objectives of the Older Americans Act or the needs that gave rise to them have changed. What has changed is our understanding of what is required to meet those needs and our view of the appropriate methodologies for best meeting those needs. By way of example, consider how our view on the subject of long term care has changed from promoting the construction of new nursing homes to devising comprehensive support systems designed to keep people in their own homes.

General Needs of Seniors

There are three mutually supporting components which all of us need to survive with dignity. These are good health, adequate life-sustaining resources and a spiritually satisfying purpose for life. When any one of these elements is removed continued existence is threatened. Older persons face high risk of expensive deterioration of health and have little opportunity to increase their incomes. For those of us concerned with the well-being of seniors, it becomes essential to promote health care and to insure that seniors have adequate life-sustaining resources.

Among the older rural Kansas I work with, I believe that the following are the most important needs:

* access to adequate affordable health care;
* protection from family impoverishment due to catastrophic illness;
* adequate long-term custodial care;
* protection from family impoverishment due to long-term care;
* safe and sufficient housing;
* effective and efficient transportation;
* alternatives to loneliness;
* comprehensive in-home services for those who can almost do everything for themselves;

* assistance in retirement planning and in dealing with the bureaucracies that provide support;
* protection from abuse;
* timely and caring substitute decision-making for those who can no-longer make decisions for themselves;
* nutrition service for the needy , shut-ins and those unable to provide for themselves;
* employment for those who can and want to work.

Meeting these needs costs money. Dollars spent must show measurable results or those who provide the dollars will grow reluctant to contribute and turn a blind eye on the need. Government policy should, in my view, set minimum standards and allow for local implementation. There is no reason why it should be easier for a senior in one rural county to get a ride to a doctor than in another rural county. There should be no reason why a senior in one county can easily get legal representation and another living elsewhere can't.

Catastrophic and Long-Term Care Support

The 1987 session of the Kansas Legislature took a bold step in passing Senate Bill 264. The Division of Assets Law. This timely legislation makes it possible for people who need nursing home care to receive Medicaid assistance while they set aside a portion of the family income and life savings for their spouse to live on. This law took effect on May 1, 1988. In the first 30 days 97 families signed up. Of these 90 had a spouse already in a nursing home. Other states which have adopted similar measures include Minnesota, California, Washington, Idaho, New Mexico and Illinois. We are hopeful that the Federal Medicaid Officials (HCFA) will not reject our new law. We take heart from the recent (June 8, 1988) passage of the Medicare Catastrophic Coverage Act of 1988 (H.R. 2470). This landmark piece of legislation will provide substantial relief to many who badly need it. The federal law contains provisions permitting Medicaid

eligibility and for protecting spouses from impoverishment for long-term care. The provisions of the federal law are very similar to the Kansas Division of Assets Law. We note, however, that the "division of assets" provisions of the new federal law will not take effect until September 30, 1989. For some seniors that day is a long way off.

Let me conclude by asking the question; What do you think your mother and father should have in their old age? Then let me ask whether anyone else's mother and father should be entitled to less?

I thank you for inviting me to testify. If you have questions I'll try to answer them.

Mr. WHITTAKER. Thank you, Pat.
Our next panelist is Joan Remmers.

STATEMENT OF JOAN REMMERS, SABETHA, KANSAS

Ms. REMMERS. I am Joan Remmers, a registered nurse and founder of the Nemaha County Home Health Agency, a not-for-profit, voluntary agency in Northeast Kansas.

I am currently past president of the Kansas Association of Home Health Agencies. I resigned as administrator of the home health agency 6 months ago. My expertise comes primarily from 8 years of experience of providing care to the residents.

As you know, our elderly are the fastest-growing segment of our population. The need to develop a comprehensive plan to meet the rapidly growing needs must remain an urgent priority. We must continue to search for cost-effective quality services. In my opinion, that can best start with long-term care services in home. We must plan strategy that includes family, neighbors, church, civic groups and professional providers to provide direct care, coordinate services.

In many, if not most instances, it is less costly to meet the needs in the home rather than in the nursing home or hospital setting.

I want to share with you a case history of a 97-year old female our agency provided care to.

Ethel lived alone on her family farm. She has poor circulation and osteoarthritis. She was paying $8.50 for one hour each week of home health aide services to assist her with bathing. One day, the home health aide noticed a large blister on her left lower leg. The home health aide notified Ethel's long-term care nurse who then came to evaluate her condition.

She was taken to her physician and treatment was initiated. The RN made daily visits to clean and evaluate the site, and apply medication and dressings for two weeks. This part of her care was paid for by Medicare.

After the ulceration was healed, Ethel resumed private pay services. Soon, Ethel's mobility and confidence improved and she was dismissed from service. Within a short time, she was admitted to the hospital with recurrent blisters and cellulitis. The blisters had been present for approximately two weeks before she sought medical attention.

The end result was ten days in the hospital with intravenous antibiotics, whirlpool treatment and leg ulcer care. That was followed by twice-daily care by the home health agency following her discharge.

Ethel then consented to resume her weekly aide services to not only bath her but also to evaluate her skin condition. Blisters did reoccur several times, treatment was initiated and Ethel was spared hospitalization. By paying $8.50 per week out of pocket she probably saved Medicare thousands of dollars.

Ethel was more the exception than the rule when it comes to paying privately for long-term preventive or maintenance care. Most would try to get by rather than pay for those services.

One out of seven Americans aged 65 and over live in poverty, according to the U.S. Bureau of Census. An even greater percentage

live near poverty. If they are financially strapped, how then can we expect them to pay out of pocket for the care that they cannot conceive as a preventive service that helps to prolong or prevent institutionalization.

We must look to their savings of health care dollars. The Home and Community Based Services is the closest move in the right direction that I have seen. HCBS is a combination State and Federal program. The recipient of this service must be financially eligible for Medicaid assistance and must be medically eligible as determined by an SRS social worker and RN.

The following is an example. An 80-year old female was admitted to a nursing home by her children who lived far away. They were concerned that she was not eating or taking her medications appropriately. One year later, all her assets had been exhausted, and the family applied for Medicaid assistance for her care.

The social worker and myself went in to screen her only to find her ineligible for nursing home care. Her home and all her personal belongings had been sold at auction. There are no group living situations in our community.

If we had followed the regulations in their strictest interpretation, she would have had to leave the nursing home and with no cash reserve and find a place on her own to stay. However, had she had assistance with her personal care, with medication assistance and meals on wheels, this probably could have been prevented.

Instead, we allowed her to remain in the nursing home for the Medicaid program to subsidize her care. The HCBS program has many shortcomings. You are not eligible unless you are determined nursing home eligible. Second, the reimbursement is often so low that it costs to provide services discouraging providers from providing care. Third, most people do not know the service exists until they are already in a nursing home.

There is much work to be done and many unknowns in looking at long-term care. However, the need is here and will only continue to grow. We must address the needs with quality, cost-effective service. Providing maintenance care in the home will not only prevent premature institutionalization, thus saving dollars in the Medicare and Medicaid programs, but it is the best way to allow an individual to maintain their dignity and self respect.

Thank you.

Mr. WHITTAKER. Thank you, Joan.

Congresswoman Meyers.

Ms. MEYERS. I will start with Joan since the microphone is there.

I am extremely interested in home care, and how can we encourage greater coordination between service providers so that we do not have one person coming in to give medication, another assistance with bathing and dressing, another to help with cooking and cleaning, another to do home chores?

I know that that was one of our concerns when I was in the Kansas legislature, and I do not know that it has changed.

I also know that this was one of the concerns with the Pepper bill that was defeated in Congress the other day. I do not think it is that Congress is not interested in home care or in long-term care. But I think they felt like the bill needed more refining and definition, and they were not quite sure how this was all going to be pro-

vided, and I heard a number of rural people saying, maybe urban people will vote for this because the services might be there, but the rural people were reluctant to vote for it because the services just were not there.

So, would you speak to that a little bit?

Ms. REMMERS. I think that probably the biggest concern is the lack of coordination. That each one of the very rural agencies want to provide that service, but financially cannot afford to keep staff on board.

So, we are usually short. The idea of using volunteers in the community, civic groups, church groups, is very appropriate. I think it is important, but what has happened in our community with the rural farm problems and crisis is the people that used to be available are now employed and that has been difficult, and we have a lot of people that are applying for jobs to do this, but they need full-time work.

So that makes it difficult. Coordination, I think. What it will come down to is there will have to be one person, whether it be a home health agency, whether it be the Area Agency on Aging, whether it be the county commissioner's office, there will have to be someone at the local level that says I will, you know, make a determination for services, and that will be some sort of a case-management type system.

I think that it takes a lot of—in our local communities, it take a great deal of time with everyone that is involved in trying to find ways to increase those services. But it is still being tossed around a lot in the State of Kansas and there are no real concrete answers to that.

Ms. MEYERS. I know that right after we got the Title 9 waiver in Kansas, we did have an inter-agency coordinating committee at the state level that was—had representatives from the Agency on Aging, SRS, Health and Environment, and there was an attempt to coordinate services so that we could provide some in-home care.

But I have been away from the state level for a few years now and did not know if that was still happening.

Ms. REMMERS. I think the only thing that I heard out of that, and this is just hearsay, is that it had been very difficult for the departments, for the major departments in Kansas to coordinate services.

So, I think if they are not able to do that, then we on a local level will have even greater difficulty being able to do that.

Ms. MEYERS. To what extent do you think—I mean, obviously, they are not going to replace them completely. There is a need for both in-home care and for nursing home care.

Ms. REMMERS. Yes.

Ms. MEYERS. To what extent do you think that in-home care can absorb the need so that the need for nursing homes may not be as great?

Ms. REMMERS. I do not know the answer to that. I know that has been talked about a lot and there is a lot of percentages. In my agency, at one point in time, we looked at just the clients that we provided care to in a population of 11,000.

So, there is a very, very small population, but what we found was that we could pinpoint at least 2 percent of our patients that had we not been providing care, then they may be in the nursing home.

The problem is being able to identify them. A lot of times, that individual would get lost. It is kind of a Catch-22. Maybe they will, maybe they will not, and sometimes they do not, and—so, you really cannot say this person would do okay without, except for some of the ones that the screenings have been done.

We have done the ACBS screenings in the home before they moved to the nursing home and have said yes, this person passed the test, they can go to the nursing home, but if they opt to stay home, we will provide services.

Ms. MEYERS. Well, it is going to be something we will have to be very interested in and concerned with before 2010 because in 2010, the baby boom hits the age of 65 for the most part.

Thank you, Joan.

Pat Donahue. I guess just going down the row this way.

When we think of the economic stability of our elderly, whether they live in rural or urban America, the first thing that comes to mind is social security.

What do you see as the role for social security? Has it been effective for our rural elderly? I know that, to me, it seems—we hear discussion and argument every once in awhile as to whether we should freeze everything at the Federal level and that would mean, of course, freezing social security and not allowing COLAs, and I have never supported that.

I have been very reluctant to do that because I know that there are a great many people who are living on just such small amounts of social security. For the most part, do you think social security is doing an adequate job?

Mr. DONAHUE. The question is, do I think social security is doing an adequate job.

Well, first, let me say I work with seniors every day and I have yet to run into any one that would very gladly give their social security check back. So, I think people do use that resource and they do depend on it.

Since I am mostly working with low-income people, I can say that they are either relying on the supplemental security income portion of social security or they are relying on rather small amounts of retirement income and they have nothing else, and that—I gave you some statistics earlier about the magnitude of that group of people, which is probably in the neighborhood of 14 percent in most of rural Kansas.

Those people that—the single individual would have an income less than $480 a month. A couple would have a combined income of $644 per month. So, 14 percent or over 1 out of 10 of all the rural elderly you run into are using that source of income to survive.

So, I think it is important that the program stay in place.

Ms. MEYERS. Thank you, Pat.

I know that the Kansas legislature just passed the Division of Assets Bill and the Division of Assets is also included in the Catastrophic Health Bill just passed at the Federal level.

What other innovative ways can we use to turn around the weakening economic status of our elderly, especially in rural areas? Do you have any ideas or thoughts?

Mr. DONAHUE. The question concerns, first of all, the passage of the Division of Assets Bill in the State of Kansas and, second, the New Catastrophic Medicare Bill, which includes similar provisions to the Kansas Division of Assets Law to prevent spousal impoverishment.

The provisions are quite similar. I must say the Federal provisions are a little more generous. They may be a little less flexible than the Kansas law.

The first problem we have to address in that regard is that it is a distinct possibility that the Kansas legislation will be attacked by HCFA as being out of compliance with the existing Medicaid law, and if that happens, maybe the new Kansas law will not be in effect very long. It went into effect on May 1.

I do not know when the earliest time the Federal Government can decide to reject the Kansas Division of Assets law.

There is a Federal law, of course, that is going to solve the problem in part, but that does not become effective until September 30th, 1989. So, there is a possibility of a gap there which concerns me a great deal.

In the first month of use of the new Kansas Division of Assets law, we had 97 people sign up, 90 of them were already in nursing homes.

There is certainly the question of whether or not the Division of Assets does enough. Does it really provide protection in a comprehensive way for the other medical needs of the nursing home residents, and I think we will have to check the new Medicare Act and see if that is going to fill all the gaps that we know are out there or whether we may need to do some more fine-tuning.

Certainly, it is a step in the right direction. At this time, I cannot really propose something else until we see how what we just picked up is going to work.

Ms. MEYERS. Thank you, Pat.

Debbie, you said that Beverly has a thousand nursing homes nationwide. What kind of planning are you doing for the years between 2010 and 2030, 40 and 50, when this enormous influx of elderly gets there?

I would assume that a giant firm like that is doing some future planning.

Ms. FORD. I think one of our biggest focuses is education. Here, we can educate the people to provide the services in a facility when we cannot provide home care. This is something that we have been made aware of and we are very concerned about.

Another thing is that we are working to encourage other people to become involved in geriatrics. We are attempting to promote the field of gerontology. The nursing home is not at the top of the list when it comes to employment.

It is very difficult to find good people to work in a nursing home. I do not know of very many people that will come by and say I want a job in a nursing home. So, we are going to continue to recruit and encourage others to get involved in the field.

We offer things like scholarships at universities to encourage them to work in the nursing homes.

Ms. MEYERS. Do you—does Beverly do any thing in the area of day care for elderly?

Ms. FORD. No.

Ms. MEYERS. Okay. Or home care?

Ms. FORD. No. Not at this point. At least in this area anyway. I am not real sure about other areas of the country, to be honest with you. We were in home health care and we are no longer in it.

Ms. MEYERS. You have commented today on the mental health services necessary for the lonely elderly, and would you describe a typical session at one of your reminiscence groups or what other activities do you provide to try to counter this loneliness?

Ms. FORD. Okay. As far as the reminiscence group?

Ms. MEYERS. Yes.

Ms. FORD. In the instances where we have attempted to take the residents back through some better times, to the times when they did feel useful, productive, to remind them that they have made a contribution to society, that their life was meaningful, and oftentimes what we find is when they are in the nursing home, they begin to use services.

We show pictures, we use different autos to try to bring back memories. We try to focus on those feelings that they have so that we can develop their self-esteem. We might talk about a time when they were successful in their job. We might talk about a time when they were first married.

Ms. MEYERS. All right. Thank you very much, Debbie.

Mr. WHITTAKER. Thank you, Jan.

Debbie, your focus has been primarily on the elderly who are in nursing homes. Given your success in meeting the needs for our elderly who are institutionalized, I am curious what Beverly is doing to take those concepts and apply them to the elderly that are not in nursing homes.

Ms. FORD. I think that we have—we are doing education. I know that we are real big on the need for community education, on promotion of the needs of the elderly, not just in nursing homes, but the elderly in general.

Mr. WHITTAKER. I'd like to pursue this point. Are there ways that you can begin to extend the care that you are giving to the non-institutionalized? Or are you totally locked in in your long-term planning to dispensing care in an institutional setting?

Ms. FORD. My focus has been more—my focus as a person has been more toward meeting those needs once they are in a nursing home. I do know that we are attempting to reach out by promoting and sponsoring programs.

Mr. WHITTAKER. Well, let me share with you a concept that is gaining discussion, particularly for rural areas where we have manpower shortages. Now, you folks are mandated in the institutional setting to provide certain levels of care, such as occupational therapy, physical therapy, and dietary care.

The point is that you have a number of services that essentially make up the components of home health care. It would be interesting if we started to see more effort on the part of institutionalized caregivers in providing more home health care services. Taking

that a step farther. I am particularly interested in the concept of combining specialists to serve the home environment.

It is very difficult in a rural area have an occupational therapist go to a home once a week, have a nurse go out three times a week to administer medication, have another specialist go out again, making multiple calls, and traveling that distance. If we had an inter-disciplinary person, who is trained and licensed in multiple professions, it would be a lot more efficient.

Do you have any thoughts toward that end?

Ms. FORD. I think I am still kind of locked into the institutionalization. I see the nursing home as a place to go for care when none of those options, none of those services work for the person, and I guess my focus is more on what we want to gain once the resident has to come to the nursing home.

Mr. WHITTAKER. That is fine, Debbie.

What special needs do the rural elderly face in the area of legal representation?

Mr. DONAHUE. I think that the statistics we deal with show that every year, the senior citizens who come to us, come to us in greater numbers. Partly, that is due to outreach on our part, but partly that is due to the fact that they are in economically difficult times, encountering more problems than they would if we had more prosperity in the State.

The other thing I noticed is that the problems they bring us are increasingly more complicated and tougher to unravel, and by that, I mean, that the person does not come to you with one legal problem, they come to you with several that are intertwined, and the first problem is for example, to help them find some relief against the contractor who did not adequately repair the leaky roof.

In the process of doing that, we find out that they cannot get a home loan to fix the rest of their home because the house passed to them through intestate succession and title is not clear and no one will loan them any money. So, you are now committed to solving that problem as well.

I think that it is important to set aside adequate resources for that service. Like all the other services, it is a link in the chain, and if we break any one of those links, people can have a serious problem.

It is not the legal service that is the most important, but it may be the most important to the individual that receives a $12,000 overpayment notice from the social security at least during the period of time, until that problem is resolved.

Mr. WHITTAKER. Well, Pat, you also talked about economic development in our rural areas. How do you feel the changing demographics of our rural elderly are affected by the shortage of economic opportunities?

Mr. DONAHUE. The problem is, as I stated earlier, one of the—the young leaving, seeking opportunities elsewhere, and the older people who have retirement incomes staying behind.

If they want to keep that community alive, they are going to have to figure out some way to keep the young people there, which means that it may be the older people that help create the economic opportunity for the young people, to ensure the community's sur-

vival and to provide them with the support and quality of life that they grew up with in that community.

Mr. WHITTAKER. When young people out-migrate, it puts a larger burden on our elderly that are left behind. In most cases, the school systems stay open, the sheriff's office still goes on patrol, and those costs continue.

We have worked very hard to bring decent highways through here. This would get the economy back on its feet so that the tax base is not so heavy on our elderly. Yet, this takes a commitment on our part to look ahead and invest that $15 or $20 a year it might take to get the pride, and get the jobs in our area, and thereby reduce the tax burden. But sometimes you have to make that initiative at the front end to get the benefits later on.

Mr. DONAHUE. That is exactly right. We have got to get some breathing room.

Mr. WHITTAKER. Okay. Joan, would you describe how providing home health care is different in rural areas than in urban areas. Does the geographic isolation make your job more difficult?

Ms. REMMERS. The difference in rural and urban, I would say, is twofold. Number one is that it is the lack of volume. The constant desire to provide quality care but lacking in the ability to hire staff in the specialty areas. That is why I cringed when you made the comment about tying them all together.

We have an RN that goes in and must be an expert on Alzheimer's, diabetes, all of the diseases, plus a case manager, plus knowledgeable on community services, plus give them their medications, and that makes it very difficult, and at the same time, be current on the latest chemotherapy.

So, keeping up on skill and being as professional as the individual deserves is very, very hard.

The second part of your question was?

Mr. WHITTAKER. How does geographical isolation make your job more difficult?

Ms. REMMERS. I would say that we probably answered that question, plus the fact that we end up dealing with specialists in Topeka, which is 70 miles from us, dealing with physicians that are long distance when the individual comes back home, dealing with many of the physicians, and I do not think that is unique to rural. I notice that also as being a problem in urban areas, too.

Mr. WHITTAKER. Joan, how often do you find the opportunity of working with informal family providers? With many of our young people moving out of our small towns and rural areas, how is the role of home health providers replacing the care that has traditionally been given by the family members and friends?

Ms. REMMERS. I would not say that we have ever finished explaining it. What I would say in our community, and again it has been my primary focus, is to keep that person independent. Get in and get out as quickly as possible.

We find community people that are available and family members that can provide care. They are strapped in their time for this service and they pull out. However, there is a unique problem in terms of personal liability.

If we educate neighbor so and so to give her medicine, if there is an error in that medication, we have the responsibility for teaching

that person or that neighbor. So, the neighbors are very good to do that, but I cannot take the responsibility for that. The liability is there.

Mr. WHITTAKER. Very good point.

Thank you, panel. We appreciate your input.

The next panel is Dr. Ernie Chaney of Wichita, Kansas, and Art Spies, who is the Administrator of the National Institute for Rural Health Policy from Des Moines, Iowa.

Thank you, gentlemen, for appearing today.

I would first like to call on Dr. Chaney.

STATEMENT OF ERNIE CHANEY, M.D., PROFESSOR, UNIVERSITY OF KANSAS SCHOOL OF MEDICINE-WICHITA, WICHITA, KANSAS

Dr. CHANEY. Thank you, Congressman Whittaker and Congresswoman Meyers.

I appreciate the opportunity to present to you some of the issues which I believe will impact on the health care needs of senior citizens in rural America.

Since the time of my presentation is very limited, I will abbreviate my introduction. I will submit printed testimony and in it you will find my historic background.

I am a Kansas physician, born and raised here in Crawford County. I graduated from Kansas. I have practiced most of my life in the rural communities in North Central Kansas and Republic County.

Belleville was a town of 3,000 citizens when I arrived here. When I left about 5 years ago, it was down to 2,800. I do not think that was my medical practice.

I spent that time in the rural area taking care of the elderly needs. I am currently a Professor at the University of Kansas School of Medicine-Wichita and Director of a 26 residency in St. Joseph Medical Center.

I would suggest to you that there are 6 areas of great concern in the health care delivery to the rural elderly, and these include: health manpower issues, increasing support for family practice residency training programs, the high cost of medical education, the plight of rural hospitals, the fee differential paid under current Medicare regulations, and the increasing medical liability issues we just heard about.

All of these factors are closely interconnected. The Federal Government has certainly been concerned about the supply of adequate numbers of health professionals and the distribution of those individuals.

The Graduate Medical Education National Advisory Committee indicated that there would be a surplus of certain types of physicians in the year 2000. Actually, in my specialty, they have indicated that we will be in pretty good shape as long as we continue to educate the number of physicians we are currently doing.

However, other studies done by the U.S. Department of Health and Human Services indicate that even taking into account physician diffusion, by the year 1999 and thereafter, there will be a large deficit in the physicians required to meet the federal shortage

area minimum levels in both metropolitan and non-metropolitan areas.

The Council on Graduate Medical Education has been examining both the supply of and demand for physicians, with its preliminary conclusions specific to primary care specialties. They concluded that there is an undersupply of physicians in family practice. They recommend incentives such as grant programs, revisions in Medicare and Medicaid reimbursement policies and student loan repayment programs to provide and assure that sufficient numbers of primary care residency programs and positions are available.

On a more personal note, as Program Director, this is a list of letters from Kansas communities that need physicians. The supply of physicians in our rural state is certainly one that everybody should know about.

I think the Federal Government has been very supportive of the health care manpower issues and particularly in the Public Service Health Act, specifically Sections 780 and 786.

I would strongly encourage this committee to support Senate Bill 2229, the Health Professionals Reauthorization Act of 1988, which was introduced on March 29.

This bill continues to fund family practice residency training programs for 3 years and will soon be considered by the Senate Labor and Human Resources Committee.

It is my understanding that legislation is being drafted which will be introduced in the House which I believe you should strongly support. While my political convictions are that a balanced budget would be helpful for all of our citizens, appropriations of $36 million for Section 786 and $7 million for Section 780 would be a wise expenditure for our rural elderly.

Another area of great concern is the plight of rural hospitals. These hospitals are impacted by increasing amounts of indigent care, bad debts, and reduced opportunities for public support through tax revenue and donations. Many rural hospitals are closing because of the lack of physicians and other health care help.

Most rural hospitals are 100 beds or under and they all need your particular attention. I think the passage of the Rural Health Care Improvement Act has helped, but I think we need to concentrate on the plight of rural hospitals.

Another issue which I draw your attention to is the practice of specialty differentiation in Medicare reimbursement. Recently, HCFA posted a notice in the Federal Register requesting comments on a possible change in regulations that govern the determination of reasonable charges that Medicare pays for physicians. I urge that all of you support formal action to eliminate those differentials.

Another area of increasingly great concern is the medical liability issue. As you know, in Kansas, we have a crisis in the State of Kansas. Some years ago, I testified before Senator Dole's subcommittee and asked him specifically to keep the Federal Government out of Kansas' liability. I do not think that is possible anymore. So, I would suggest that you take a look at that.

We also need to look at the cost of medical education. Many medical students now complete their graduate training with debts in excess of $35,000. Physicians then look towards going into special-

ties which pay them a higher return so they can pay off those bills, and one of those specialties is family practice.

I think it also important that you have these meetings in rural areas. It seems to me most of the time I see studies done on how to help rural Americans done in Philadelphia or Chicago, and we appreciate your coming to Kansas.

Thanks.

[The prepared statement of Dr. Chaney follows:]

The University of Kansas Medical Center
School of Medicine-Wichita

TESTIMONY BEFORE THE SELECT COMMITTEE ON AGING

McCray Hall
Pittsburg State University
Pittsburg, Kansas

Monday June 13, 1988

Presented by

Ernie J. Chaney, M.D.

Professor
University of Kansas School of Medicine-Wichita

Director
St. Joseph Family Practice Residency Training Program

Mr. Chairman and members of the Committee:

I appreciate the opportunity to present to you some of the issues which I believe will impact on the health care needs of senior citizens in rural America. Since the time of my presentation is very limited, I will abbreviate my introduction. I will submit printed testimony and in it you will find my historic background. (I am Ernie J. Chaney, M.D., a Professor of Family and Community Medicine at the University of Kansas School of Medicine-Wichita and Director of the St. Joseph Family Practice Residency Training Program. I am a graduate of the University of Kansas School of Medicine and have practiced in northcentral Kansas in Republic County from 1957 to 1983. I joined the faculty of the University of Kansas School of Medicine-Wichita in 1983 and have been Director of the Residency Training Program at St. Joseph Medical Center since that time. I have had the privilege of serving as President of the Kansas Academy of Family Physicians and also as President of the American Academy of Family Physicians, this country's second largest medical specialty society. I currently serve as President of the Family Health Foundation of America, the philanthropic arm of Family Medicine. I serve as a technical advisor to the Harvard-AMA Resource Base Relative Value Study, and I am actively involved in the practice of Family Medicine, with particular interest in Obstetrics and Gerontology.) I am Ernie J. Chaney, M.D., born in Crawford County, KS at Mt. Carmel Hospital when the hospital was situated halfway between Pittsburg and Frontenac. I am a graduate of the University of Kansas School of Medicine and have spent the majority of my medical career delivering health care to rural citizens in a community in northcentral Kansas in Republic County. Belleville, Kansas had a population of 3,300 when I started practice but had diminished to 2,800 by the time I left. The county used to have approximately 11,000 citizens but is currently down to

about 8,000 people. I am currently a Professor at the University of Kansas School of Medicine-Wichita in the Department of Family and Community Medicine and a Program Director in a 26-resident Family Practice residency training program at St. Joseph Medical Center.

I would suggest to you that there are six areas of great concern in the health care delivery to the rural elderly. These include:

1) Health manpower.
2) Increasing support for Family Practice Residency Training Programs.
3) The high cost of medical education.
4) The plight of rural hospitals.
5) The fee differential paid under current Medicare regulations, and
6) The increasing medical liability crisis.

All of these factors are closely interconnected. The federal government has certainly been concerned about the supply of adequate numbers of health professionals and the distribution of those individuals. The Graduate Medical Education National Advisory Committee (GMENAC) indicated that there was a surplus of certain types of physicians and that that surplus would exist until the turn of the century. Other studies, such as those done by the U.S. Dept. of Health and Human Services[1] indicated that, even taking into account physician diffusion, by 1994 and thereafter there

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[1]ODAM report #4-83, June 1983

will be a large deficit in the physicians required to meet the federal shortage area minimum levels in both nonmetropolitan areas and metropolitan areas.

The Council on Graduate Medical Education (COGME) has been examining both the supply of and demand for physicians, with its preliminary conclusions specific to primary care specialties of general internal medicine, general pediatrics, and Family Practice. In its preliminary recommendations, COGME has concluded that "there is an undersupply of physicians in Family Practice." COGME then recommends that "incentives such as grant programs, revisions in Medicare and Medicaid reimbursement policies and student loan repayment programs must be provided to assure that sufficient numbers of primary care residency programs and positions are available to meet the needs of society."

On a more personal note, I can report to you that the state of Kansas is greatly in need of Family Physicians. Here are but a few letters written to me as Program Director from communities seeking Family Physicians. The federal government has been concerned about these health manpower needs and has been responsive to those needs by the implementation and support of federal programs such as the Public Health Service Act, specifically Sections 780 and 786. I would strongly encourage this committee and other members of congress to support Senate Bill 2229, the Health Professionals Reauthorization Act of 1988, which was introduced on March 29th by Senator Kennedy. This bill continues to fund Family Practice residency training programs for three years and will soon be considered by the Senate Labor

and Human Resources Committee. My understanding is that Representative Waxman is drafting reauthorization legislation which will be introduced in the House and which I believe you should strongly support. While my political convictions are that a balanced budget would be helpful for all of our citizens, appropriations of $36 million for Section 796 and $7 million for Section 780 would certainly be a wise expenditure and one that would benefit the rural elderly.

Another area of great concern is the plight of rural hospitals. "These hospitals are impacted by increasing amounts of indigent care, bad debts, and reduced opportunities for public support through tax revenue and donations."[2]

The second problem for rural hospitals is their inability to respond to pressure created by the evolving American health care system. These include restricted reimbursement by public and private payors with the resulting conflict between cost containment and access, shifting the locus of care from inpatient to outpatient settings, inadequate supply of health personnel in rural areas, increasing competition for patients, and increasing need for capital by these institutions. All of these factors help to explain why many rural hospitals are experiencing economic distress and are considering or implementing plans for closure.[2]

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[2]Rural Hospitals: Literature Synthesis and Health Services Research Agenda, Rural Health Services Research Agenda Conference, San Diego, CA, December 13-15, 1987.

Supportive legislation such as the Rural Health Care Improvement Act (SOBRA) are useful as well as legislation which would eliminate the urban-rural differential in hospital reimbursement by Medicare. Most rural hospitals have fewer than 100 beds and will require specific individual attention to prevent communities from losing their hospitals.

Another issue to which I draw your attention is the practice of specialty differentiation in Medicare reimbursement. Recently the Health Care Financing Administration (HCFA) posted a notice in the Federal Register requesting comments on a possible change in regulations that govern the determination of reasonable charges that Medicare pays for physicians. I urge that all of you support action to formally eliminate specialty differentials through the regulatory process.

Another area of increasingly great concern is the medical liability issue. I have enclosed in the printed material testimony given to the Kansas House and the Kansas Senate Judiciary Committees concerning that serious crisis. This will not only affect the health care delivery of all reproductive age females in Kansas, but will also add the possibility of closing rural hospitals, which will certainly impinge on health care of the rural elderly.

Some years ago I testified for Senator Dole's subcommittee concerning medical liability and specifically requested the federal government refrain from action on the liability issue and allow each state to develop their own solutions. However, it has become abundantly clear that at least the state of Kansas is unable to do that, and unless some solution is found to

this extremely serious problem, a change in the health care delivery system, which will be devastating for rural inhabitants, will surely occur.

Lastly, the recruitment and retention of Family Physicians to rural America is essential if we are to maintain the high quality of medical services that that population deserves. There are currently 382 approved residency training programs in the specialty of Family Medicine and, as I have previously stated, they will need support from both state and federal governments for their continued existence. It is important that we recruit medical students into the specialty of Family Medicine to serve in rural areas, and many medical students now complete their graduate training with debts in excess of $35,000. Because of the high cost of medical education, they may enter specialties which can afford them a greater chance for paying these high debts. In both academic medicine and private practice, Family Physicians are at or near the bottom of the income levels for physicians. Some attention needs to be focused on this problem.

(I serve on the Technical Advisory Committee for the Harvard-AMA Resource Base Relative Value Study and believe that a new Relative Value Scale may be of some help in attaining a more equitable distribution of income. However, a single Resource Base Relative Value Scale for each distinct physician services should be adopted. The use of a Relative Value Scale that incorporates differentials by type of specialty, practice, or geographical location would perpetuate inequities that exist in the current system.) *For use in printed testimony--not oral.

Additional aid to encourage rural practice may be necessary in the form of increasing the support for student loans with forgiveness of those loans for serving in underserved areas. It may also be helpful to develop income tax or other incentives to help recruit and maintain physicians in rural America.

I want to thank members of this Committee for allowing me to participate in this hearing and for your interest in the problems concerning the health of the rural population.

Yours,

E. J. Chaney, M.D.
President, Family Health Foundation of America
Director, Family Practice Residency Program
Professor,
Department of Family and Community Medicine
University of Kansas School of Medicine-Wichita

EJC/ss

Mr. WHITTAKER. Thank you, Doctor. Art.

STATEMENT OF ART SPIES, ADMINISTRATIVE DIRECTOR, NATIONAL INSTITUTE FOR RURAL HEALTH POLICY, DES MOINES, IOWA

Mr. SPIES. Representatives Meyers and Whittaker, I would like to thank you very much for inviting the National Institute of Rural Health Policy to come down and participate in this field hearing.

I would also like to thank Representative Meyers for her activity in addressing elder issues as a member of the Select Committee on Aging, and to thank Representative Whittaker for your involvement and action in addressing rural health issues, as a member of the House Rural Health Coalition, and in introducing legislation such as H.R. 2708, that assists rural hospitals in dealing with Medicare's payment inequities.

Besides including some background information on the National Institute in my testimony, I hope I have demonstrated the importance and contribution of the rural health care system and have attempted to put rural health care in perspective.

Nationally, about 20 percent of the care, hospital care, is provided by rural hospitals, and as we come to the Midwest, the importance and contribution of rural hospitals can easily be doubled.

Forty to 50 percent of the care is provided by Kansas and Iowa rural hospitals.

Since 1980, the health care system, particularly the rural health care system, has undergone unprecedented dramatic change. The implementation of Medicare's DRG prospective payment system coupled with the heightened regulation of practice in medicine through PRO utilization review have dramatically affected the operations and finances of rural hospitals.

In rural America, there are 30 percent fewer admissions and 28.5 percent fewer patient days in 1986 than in 1980. More profound reductions occurred in Kansas and in Iowa.

In addition to changing utilization, rural hospitals have faced changing payment systems that provide inequitable and inadequate payment for services provided to rural elderly. I think we are all well aware of the urban-rural payment differentials.

As of April 1, 1988, the differential still exists and it exists heavily in the Midwest. In Kansas, your rural hospitals are receiving 27.2 percent less than their urban counterparts. In Iowa, that difference is 33.5 percent. Action by the Rural Health Coalition helped to bring that down from higher levels in prior years.

There are many other problems that rural hospitals face. One of them already mentioned was medical and technical personnel shortages, but, more importantly, they are facing the changing demographic base and community needs.

The long-term strategic issue that rural America and rural hospitals face is the aging of rural America. We are all familiar with those statistics.

As rural America ages, the needs of the elderly are also changing. In addition to acute care needs, there are other health care and social or life style services and transportation services that are now needed to keep the elderly in an independent non-institutional

setting, which sounds kind of funny for somebody from a hospital association, but I think that is the reality.

The new services will create financial challenges for both public and the private sector.

As part of the Iowa Hospital Association and the National Institute's concern about access to health care services for the elderly, we called upon a number of elder groups in Iowa, including the American Association of Retired Persons, the Iowa Area Agencies on Aging, the Iowa State Department of Elder Affairs, and the Council of Senior Citizens, to advise us on what are some of the critical problem areas and needs of the elderly.

Some of those include: after hospital care is not readily available because of lack of payment and prohibitive regulations on the acute care side. There is a need for better discharge planning and better coordination of services and sources of service information for the elderly.

There is a need for affordable transportation services, lifeline services, education on Medicare supplemental insurance policies, various provisions of the Medicare program, including PRO review, and awareness of various preventive, screening, diagnosis and treatment services.

The need exists to create a central agency or organization that will coordinate all services available to the elderly within each community. The agency must be easily accessible and should be recognized as the initial point of contact for information and referral to other resources. Local hospitals, especially those located in rural areas, may be the most appropriate organization to fill this need.

There have been a number of strategies pursued by hospitals in addressing the needs of the elderly and responding to the new environment.

What I would like to do is mention two strategies that have been pursued in Iowa that we believe are very important.

The first is an example of a successful case management effort that has been undertaken in Linn County, Iowa. Fourteen community agencies in Linn County have joined together to operate a multi-disciplinary Linn County case management project.

An article that describes this particular program is attached to the testimony.

The second innovative strategy is being developed is by the Auxillians of Iowa Hospitals. Through training, Auxillians will now assist the elderly in completing and understanding Medicare payment forms. Iowans helping other Iowans.

Within the written testimony, I have included several recommendations, which I will not go into right now.

The leadership role in setting policy and financing must come from Congress, as has been demonstrated by your efforts. A strong national policy and funding mechanism for health, transportation, and social services needed by rural elderly will encourage both State, local and private development.

The Iowa Hospital Association and the National Institute for Rural Health Policy supports and endorses the House Rural Health Coalition's 1988 legislative agenda. Provisions to remedy the shortage of rural health professionals, such as physicians and RNs, and

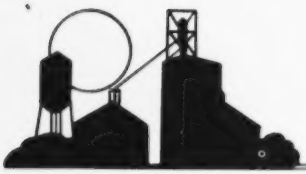
to improve access to Medicare HMO coverage by rural residents are vital to America's elderly.

We appreciate this opportunity to participate in this field hearing.

The Iowa Hospital Association and the National Institute pledge to work with you in seeking solutions to the problems and needs of rural America.

Thank you very much.

[The prepared statement of Mr. Spies follows:]



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U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON AGING
FIELD HEARING

Pittsburg State University
Pittsburg, Kansas

June 13, 1988

by
Arthur J. Spies, Administrative Director
National Institute for Rural Health Policy

Representative Meyers and Whittaker, I am Art Spies, Vice President with the Iowa Hospital Association and Administrative Director of the National Institute for Rural Health Policy. I would like to thank you for inviting the National Institute to participate in this field hearing held by the House Select Committee on Aging.

The National Institute for Rural Health Policy was established in 1986 and is sponsored by the Iowa Hospital Education and Research Foundation in association with the University of Iowa Center for Health Services Research. The Institute is a nonpartisan research center whose mission is to affect rural health policy and improve the health status of rural Americans.

Initiatives of the Institute include policy analysis and applied research, educational activities, demonstration projects and information dissemination. The Institute initiatives are focused on four broad areas of concern which are access to rural health care services, care of the rural elderly, rural maternal and child health, and rural occupational health. Both the Iowa Hospital Association and the National Institute for Rural Health Policy are concerned with access to rural health care services and the special and changing needs of the elderly in rural America.

Status of Rural Health Systems

Before I describe rural health and medical service trends, we first need to put the rural health care system into perspective.

* Nationally, 47 percent of the hospitals, 23 percent of the beds, and approximately 20 percent of the admissions, patient days, surgery, emergency room outpatient visits, and births are provided by this nation's rural hospitals. The rural hospitals employ about 16 percent of the hospital personnel and generate 13 percent of the expense.

In Kansas and in Iowa, the importance and contribution of rural hospitals can be doubled.

* Eighty-five percent of Kansas hospitals are rural and contain 58 percent of the beds and generate 48 percent of the admissions, 51 percent of the days, 41 percent of the surgeries, 47 percent of the emergency room outpatient visits, 44 percent of the births, employ 41 percent of the hospital personnel, and generate 37.7 percent of the expense. Figures of Iowa's rural hospitals are very similar to Kansas.

Since 1980, the health care system--particularly, the rural health care system--has undergone unprecedented dramatic change. At the federal level, implementation of the diagnosis related group prospective payment system and heightened regulation of the practice of medicine through PRO utilization review have dramatically affected the operations and finances of rural hospitals.

* Nationally, from 1980 through 1986 hospitals admissions dropped 7.5 percent and patient days dropped 14.5 percent.

* In rural America, there were 30 percent fewer admissions and 28.5 percent fewer patient days in 1986 than in 1980.

More profound reductions occurred in Kansas and Iowa. During that time, growth in outpatient activity and long term care--particularly Medicare's swing bed program--also occurred. In addition to changing utilization of hospitals, rural hospitals have faced changing payment systems that provide inadequate and inequitable payment for services provided to the rural elderly.

* As of April 1, the urban-rural payment differential in Iowa was 33.5 percent. Iowa's small rural hospitals were paid 33.5 percent less than their urban counterparts.

* In Kansas, small rural hospitals are typically receiving 27.2 percent less than urban hospitals.

Payment increases in the Medicare program have not kept pace with expenses. Reduced utilization, coupled with strict utilization review, has resulted in sicker patients being admitted to rural hospitals requiring additional resources for treatment and longer lengths of stay. Medicare payment increases have fallen short of inflation, therefore expenses in Iowa rural hospitals have increased faster than net revenues (the money hospitals actually receive for patient service) resulting in an erosion of profit margins. Profit is a misnomer. Iowa rural hospitals have consistently lost anywhere from 2¢ to 6¢ on every dollar of patient care revenue received since 1982.

Rural hospitals face other problems such as facility and equipment obsolescence and compliance, limited access to long-term and short-term capital, medical and technical personnel shortages, the level and scope of governmental, payer and voluntary regulation, and changing demographic base and community needs such as the aging of rural America. These changes have taxed America's rural hospitals. Since 1982, 137 rural hospitals have closed. Those hospitals contained 6,469 beds. More importantly, the number of hospitals that have closed annually is increasing. In 1982, 14 rural hospitals closed, and in 1987, 40 hospitals closed. This points to the seriousness of America's rural hospital operating environment.

The long term strategic issue that rural America and rural hospitals face is the aging of rural America.

- Nationally, the elderly represent 11.3 percent of the population, but by the year 2050 more than 1 out of every 5 persons will be 65 years or older. In the rural midwest, the elderly account for a greater proportion of the population.

- In Iowa, 14.1 percent of the population is over age 65. Over 27 percent of Iowa's counties are reporting an elderly population in excess of 18 percent; 42 percent elderly Iowans reside in rural areas.

- In Kansas, 13 percent of the population is over age 65; 38 percent of the Kansas elderly reside in rural areas.

- The fastest growing population group is persons over 75. Presently, this age cohort makes up 4 percent of the total population. By the year 2050, their proportion is expected to double. Generally, individuals in this age group are more likely to be female with few assets and often are dependent upon family or outside agencies for assistance in activities of daily living. This group is of particular interest to policymakers since they are the largest users of publicly financed services and programs.

The elderly consume a disproportionate share of acute services. In Iowa, 14 percent of the population consumed 30.7 percent of the discharges and 37.7 percent of the patient days. Most of that acute care is for chronic illnesses such as heart disease, arthritis, hypertension, hearing and vision impairment, orthopedic problems, diabetes, and cognitive impairment.

As rural America ages, the needs of the elderly are also changing. In addition to acute care needs, other health care, social or life style services and transportation services are now needed to keep the elderly in an independent noninstitutional setting. These new services will create financial challenges for both public and private sectors.

Health Issues and Needs of Rural Elderly

As part of our concern of access to health care services to the elderly, representatives of elder advocate groups in Iowa including American

Association of Retired Persons, Area Agencies on Aging, State Department of Elder Affairs, and Council of Senior Citizens advise the Iowa Hospital Association of several problem areas and needs of the elderly.

- After-hospital care is not readily available because of lack of payment and prohibitive regulations on the acute care side.
- There is a need for better discharge planning and better coordination of services and sources of service information for the elderly.
- There is a need for portal to portal transportation services, lifeline services, education on Medicare supplemental insurance policies, various provisions of the Medicare, including PRO review, and awareness of various preventive, screening diagnosis and treatment services.

Because of changing demographic characteristics and budget limitations, transition by rural health providers and payment for these new services is slow or does not exist. The overarching problem is the lack of coordination of services for the elderly. The need exists to create a central agency or organization that will coordinate all services available to the elderly within the community. The agency must be easily accessible and should be recognized as the initial point of contact for information and referral to other resources. Local hospitals, especially those located in rural areas, may be the most appropriate organization to fulfill this need. While coordination of services is important for all elderly, it is particulary important for the rural elderly who tend to be older and more likely to be isolated both geographically and socially than their urban counterparts.

Strategies to Improve Access to Health Services By The Rural Elderly

Strategies which have been pursued by hospitals and others to ensure access are many and varied based on community needs and resources.

- Rural hospitals have responded by consolidating inpatient services into an appropriate economic size striving to use existing resources more effectively, such as using multiskilled personnel reducing the number of personnel and, of course, using fewer beds.
- By recruiting needed physicians (both primary care and specialists) and establishing periodic specialty clinics in such areas as orthopedics, cardiology, otolaryngology, and opthalmology.
- Rural hospitals have diversified their revenue and service portfolios along the health care continuum. The swing bed program, other long term care, outpatient care services, home health care, day care, and supervised independent living for the elderly are several programs pursued.
- Rural hospitals have implemented many different programs for the elderly such as health lifeline programs, meals-on-wheels, congregate

meal sites, wellness programs, screening programs, education programs, and transportation services.

- Rural hospitals are networking, investigating and, if appropriate, pursuing multi-institutional multiprovider arrangements including shared services, cooperatives, joint ventures, affiliations or networks such as VHA and management contracts.

- The fourth and most important strategy pursued by hospitals is defining and implementing a new mission and business focus. Rural hospitals are expanding the mission and business focus of the hospital into a health and social service center, functioning as the hub of the community health and social service system.

These strategies by rural hospitals are being pursued not only in Iowa but in Kansas and across the country. As I mentioned earlier, the critical problem is the lack of coordination of services. One method for coordinating services to the elderly is through comprehensive case management. The goal of case management is to coordinate access and provide necessary community services to frail and vulnerable elderly, therefore helping them avoid unnecessary utilization and inappropriate nursing home placement. This is achieved through review of cases by a case management team made up of members from all the area agencies which provide services for the elderly. A case plan is developed with the cooperation of the client and the family. This approach is a good way to maximize service provision, particulary in rural areas where resources are scarce.

An example of a successful case management effort has been undertaken in Linn County, Iowa. Fourteen community agencies in Linn County have joined together to operate the multidisciplinary Linn County Case Management Project. Through this project, a variety of services are offered, including adult day care, home health care, transportation and acute care services. Since its inception in 1982, the number of cases being managed has risen from 23 to over 100. Results of this program have been that service delivery has been enhanced, quality of life has improved and costs have been reduced by 50 percent. I have attached an article regarding the Linn County, Iowa case management project, to my written testimony. There is no payment for this service; therefore, a limited number of elderly could be served.

A second innovative strategy being developed by the auxilians of Iowa hospitals will assist the elderly in completing and understanding Medicare payment forms. This is a project undertaken by the auxiliaries during their 1988 program year. Training programs for auxilians from each hospital were held during February 1988. Implementation of this program is being determined by the local auxiliary.

What Is Needed?

Many of the health related needs of older adults are not strictly medical. These people also require education, coordination of services,

transportation, support services or custodial care. The structure of our health care system is mismatched to the needs of the elderly. Financial and regulatory incentives do not exist which allow the development of a communitywide network which offers, as Ken Dychwald describes it, "a diversified spectrum of health and social services in a communitywide integrated network driven by a one-stop-shop case management system."

We would recommend the following actions for Congress's consideration:

1. Adoption of a federal health policy to allow and encourage rural hospitals to be the focal point for health and social service provision. Removing payment or other regulatory obstacles is also critical. Transportation and social services for rural America should be underwritten sufficiently to assure access to and coordination with acute, emergency and long term care services.

2. Payment to rural hospitals for Medicare patients must be increased. The inequitable payment difference between rural hospitals and urban hospitals must be eliminated.

3. Adequate payment for nonacute care services is imperative. Federal policy has encouraged less inpatient acute care and more outpatient care, long term care and home health care. Adequate payment for these nonacute services must follow.

4. Rural providers must have regulatory and payment flexibility. Regulatory obstacles blocking rural providers from quickly responding to changing community needs must be eliminated. Conflicting regulation in payment policies must be identified and eliminated.

5. A federal health care and social policy for the elderly needs to be developed. The policy should recognize the need for financial and geographic access to health care all along the health care continuum and the existence of proper financial and regulatory incentives allowing the development of health, transportation, and social services needed by rural America's elderly.

6. Rural hospitals should be encouraged to convert idle acute resources to other health care services needed by the elderly and the poor. While a federal grant program providing financial assistance to rural hospitals in converting idle capacity was legislated last year, funds need to be appropriated for that grant program. Small rural hospitals need that financial assistance for the conversion of idle capacity, training of existing personnel and recruitment of new health care professionals.

The leadership role in setting policy and financing must come from Congress. A strong national policy and funding mechanism for health, transportation, and social services needed by rural elderly will encourage state, local and private development.

Our current concerns are for the continued availability and access to quality care by rural Americans, especially the rural elderly. As suggested earlier, America's rural hospitals are providing diversified services to better serve their communities. The future rural hospital does need to continue to provide smaller amounts of acute and emergency care. To remain viable, however, especially in sparsely populated areas, it needs to be a community health and social services center. The gamut of noninpatient acute care services being provided will increase as rapidly as hospitals and other providers can overcome various regulatory and financial barriers.

A rural health care system of the future will offer a diversified spectrum of health and social services in a communitywide network driven by "a one-stop-shop case management system." The hospital can serve as the focal point for this network.

We appreciate this opportunity for comment on factors that have inhibited access to health care services by the rural elderly, strategies pursued by rural hospitals and other providers that enhance the rural elderly's access to health and social services, and identification of several initiatives Congress can pursue. The Iowa Hospital Association and the National Institute for Rural Health Policy pledge to work with you in seeking solutions to problems and needs of rural America.

Thank you very much.

AJS:bja

Mr. WHITTAKER. Thank you, Art. Congresswoman Meyers.

Ms. MEYERS. I became immediately more alert when you mentioned Linn County because Linn County, Kansas, is in my district. It used to be in Bob's district.

The case management system that you say has been successful in Linn County, Iowa, how could that be modified and applied to a more rural area?

Mr. SPIES. There are a number of agencies that are involved in that. Fourteen in number. Such as home health care services, United Way, hospitals, home health care agencies, departments of health, departments of human services.

Many of those agencies also have offices in rural settings. Through their own initiative, these agencies got together, on a voluntary basis without additional payment, to take a coordinated case management approach, and, so, I think that the needed services are already there.

It is the time and effort that needs to take place to bring all these services together under one coordinating agency.

The major limiting factor is the lack of funding. Currently other agencies volunteer their time and resources to perform this function. So, I think funding these programs is one of the challenges that we face.

How do we get that over-arching coordination that is needed.

Ms. MEYERS. Thank you.

Dr. Chaney, I understand that you are involved in the development of geriatric education and research institute.

Could you tell us what the role of the institute is and a little bit about it?

Dr. CHANEY. Yes. Thank you, because we got our grant to teach geriatric medicine to graduate residents through a grant from the Federal Government. Out of that sprang the institute.

So, we have just started it. We hope that it will continue to be just what it says, an institute that encourages education of the family physician because they are one of the primary caregivers in rural America and particularly to rural elderly, but also to other paraprofessionals, nurses, physical therapists, to the spiritual aspect of the care of the individual, maybe even teaching social workers other things in our older adult assessment team which we have developed.

I think that is something that should be encouraged because older adult assessment is something that needs to be done and needs to be done in a unified multi-disciplinary fashion, which we have started.

It is also doing some research. Currently, we are looking at the effect of long-term grief. The elderly population is one of the areas in the country that has been woefully neglected as far as research. Social research and other activities.

So, I think is just now that we have awakened to the idea that we need to do a lot of things to find out more about our elderly. So, I believe that a regional geriatric institute and research center can be helpful.

One of the problems we are facing is that, once again, people say that is a good idea, but they want to put it in Newark or Pittsburgh, Pennsylvania, and, so, you need to make sure that they are

put in areas where people what rural America is like, and if you look at some of the fellowship grants, they are only done in medical schools having departments in dentistry.

I would suggest to you that Woodson, Kansas, is a pretty good place to study rural America. We do not have the schools of dentistry, so we cannot have fellowship grants. So, I think we need to go back and look at that.

Ms. MEYERS. Thank you very much, Dr. Chaney.

Mr. WHITTAKER. Thank you, Jan.

Doctor, we are very much aware of the efforts the Federal Government has made to attract physicians into the rural areas. From your perspective on the front line, do you feel that the Federal programs have been successful in getting these doctors into the rural areas?

Dr. CHANEY. No, absolutely not.

I think the Health Service Corps has been a failure for many reasons, not the least of which they do not put the people in the area of need, and sometimes if you have a physician there who is just there to pay off his debt and does not want to stay, that prevents another physician from coming in.

I think we have to emphasize that there are certain specialties that do well in metropolitan areas and certain specialties that do not do well in rural areas, and we have to recognize the need to train those particular types of physicians.

I do not know the answer, but I think we ought to look at tax incentives. The rural payment for physicians in rural areas is not as great. The cost to deliver health care services, on the other hand, does not go down when you move out to the rural areas.

So, besides that, you have to convince your wife that it is a nice place to live.

So, I do think it is important that we look at incentives to try to recruit family physicians in to rural America.

Mr. WHITTAKER. Doctor, you have referred to the rural-urban concept toward specialization. Do you think that the trend towards specialization has hurt the rural area then rather than helped it?

Dr. CHANEY. Well, I think it tells you the fact that the family physicians are now recognized as a specialty, the twenty-second recognized specialty since 1969. That is great. That has given us a status that we did not have before.

I think what we have had happened, though, is the increasing cost of medical practice and education, and particularly the liability issues, have driven people to high-paying jobs, and in medicine, we pay people an awful lot of money if they can do technical things. You do not get paid very good just to think, and I think that is one of the things we have got to address with the resource base relative to value studies that are being—will be handed over the 14th of July for you to take a look at.

If that is structured so that we still may be down here thinking and up here we are doing, it will not do very much. It ought to be evened out a little bit so that the technicians are paid justly, but other people who do not do the technical things are treated more fairly.

Mr. WHITTAKER. Doctor, are you satisfied with the number of physicians that we are attracting into the geriatric specialty?

Dr. CHANEY. No. I think we need many more, and that is one of the reasons the American Board of Internal Medicine or Family Practice has developed a certificate and added a qualification in geriatrics.

One of the reasons we need funding to teach people geriatrics, our residents have to learn from my experience and one other physician in our residency faculty who has an interest in geriatrics, we need to train them to understand geriatrics so they can go out and train other physicians.

So, that is a need that is very obvious.

Mr. WHITTAKER. From your perspective, what we can do to attract more nurses in geriatric care?

Dr. CHANEY. I think probably health care delivery, particularly amongst nurses and paraprofessionals, has not been adequately reimbursed. I think that is changing as the years go by, but it still has not been adequately reimbursed.

I think education is the thing. There is not anything in my field, and I think probably so in nursing, that is more interesting and satisfying than taking care of the elderly population. So, I am interested, interestingly enough, in obstetrics and gerontology, but I think we need to educate people that there is a great deal of pleasure to be derived in taking care of elderly people.

Mr. WHITTAKER. I was fascinated with your comment, about the differences of medical liability for the rural doctor versus the urban.

You are contending that because of the lower gross income that a rural doctor may have, he really cannot easily afford to stay in the rural setting as long as he high liability costs.

Dr. CHANEY. Impossible to do. In the field of obstetrics, if you deliver—most rural physicians will deliver 30, 50 babies a year. If you increase the cost of their liability insurance by $10,000, divide that by 50, you can see what he is going to have to ask each patient to pay. Where are you going to get the money?

The thing for the physician to do is to say I will not deliver the babies or if the cost of the liability insurance for taking care of the elderly grows so high, they will just quit. Part of the problem in our specialty numbers is a lot of us are retiring because we do not want to put up with that.

In addition to the financial liabilities, the emotional liabilities of defending lawsuits, many of which are frivolous, but it sure impacts.

Mr. WHITTAKER. Okay. My last question, Dr. Chaney, is, what percentage of the care in rural areas is performed by the family physician, rather than the traditional specialist that you normally find in the metropolitan areas?

Dr. CHANEY. Well, I tell our residents as they enter our program that by the time they are through, if I have done a good job in education, they should be able to take care of 90 to 95 percent of the things that are brought to the family physician offices.

Obviously, that other 5 or 10 percent needs our limited specialists to take care of, and we need to educate those individuals, also. But given rural America and the technology that is there, I think the individual family physician is much better prepared to administer the total care of the person than the limited specialist.

Mr. WHITTAKER. Thank you, Doctor.

Art, I would like to ask a question about your National Institute of Rural Health Policy.

How much effort have you done in your institute towards researching future trends and the delivery of that care?

Mr. SPIES. Very little, to be honest with you. We are an emerging organization. We are in the process of applying for grant money that was legislated last year for rural research centers and administered through the Office of Rural Health Policy, and, so, at this time, we have not done any forecasting.

Mr. WHITTAKER. Okay. Thank you.

Well, ladies and gentlemen, this concludes our hearing. I did emphasize at the beginning that we do want to keep the record open. We have some individuals here, in particular Ms. Reinhart, from the Kansas Farm Bureau, and Mr. Garrison from Southeast Kansas Community Action, that have some testimony. I assure you we want that in the record. Likewise if there are others that have information that could be beneficial in addressing the needs of our rural elderly, please submit those comments to the committee for inclusion within the record.

Again, I thank you very much for participating.

Ms. MEYERS. Thank you.

[Whereupon, at 3:30 p.m., the hearing was adjourned.]

APPENDIX

Kansas Farm Bureau

PUBLIC POLICY STATEMENT

U.S. House of Representatives
Select Committee on Aging

Field Hearing

Re: Special Needs of Rural Elderly and Aging

June 13, 1988
McCray Hall
Pittsburg State University
Pittsburg, Kansas

Presented by:
Linda Reinhardt, Chairman
Women's Committee
Kansas Farm Bureau

Mr. Chairman and Members of the Committee:

We consider it a privilege to bring to your attention, the Select Committee on Aging, some of the special needs of the rural elderly. We commend you for conducting a Field Hearing in Pittsburg, Kansas on this topic.

My name is Linda Reinhardt. I am the Chairman of Farm Bureau Women in Kansas, a member of the American Farm Bureau Federation Women's Committee, and a Member-At-Large of the Kansas Farm Bureau Board of Directors. I am here today representing the more than 126,000 member families of Farm Bureau in Kansas.

We want to bring to your attention some of the special needs of the rural elderly. Those needs are in a number of areas. We will focus on some of the needs most pressing in such areas as Health Care, Transportation, Taxation, and Social Security.

For many of our elderly, nursing home care will become a necessity. For others, remaining in their own homes will be a far preferable option. We believe health care programs should maximize the independence of the elderly for as long as possible.

In health and nutrition many things are needed. I will highlight but a few. We support:

(1) Legislation to allow 100% federal income tax credits or tax deductions for those who self-finance their health insurance;

(2) Greater use of non-physician providers to help relieve personnel maldistribution in the medical profession;

(3) Efforts of medical schools to train additional qualified family physicians who intend to practice medicine in rural areas;

(4) Economic inducements to encourage doctors to practice in rural areas (Kansas Farm Bureau has initiated, along with the Kansas Medical Society, a program known as MEDISERVE. Our program provides financial stipends for candidates at medical school who will agree to practice in an underserved rural area of Kansas in one of the basic general practice/family practice specialities.);

(5) State and federal government policies that provide incentives for medical and mental health services in rural areas;

(6) Efforts at every level of government to reduce medical malpractice insurance costs;

(7) Third-party payer recognition for payment of outpatient treatment and preventive measures.

While still on the topic of health and nutrition, I must say to you that we are opposed to compulsory national health insurance in any form.

One of the things we have done in Kansas that should be reviewed as a possibility at the congressional level, something to

dovetail with our new Kansas law, relates to what we call Division of Assets. Because medical care, medical assistance, and nursing home care are becoming increasingly expensive, those types of care often deplete the assets of families rural and urban. That depletion threatens to bankrupt families. We urge this Committee and the Congress to give careful consideration to legislation which might be developed to protect against such financial disasters. We believe legislation at the federal level, similar to what was passed in Kansas just this year, should permit spouses to divide their income and resources, including cash or other liquid assets and real and personal property, in order to become eligible for or to remain eligible for medical assistance or nursing home care.

Transportation

Adequate transportation is tremendously important to our rural elderly. In this day and age, when more and more bus line consolidations are taking place, and less and less bus transportation is available in many communities throughout Kansas and throughout the Nation, we believe this matter deserves serious attention by the Congress. We should have a national transportation policy that indicates a willingness to find a shared responsibility for providing such service. The beneficiaries of a good transportation system are not just the elderly. They include retail business and service providers when the elderly must leave their community and go many miles for the service or to be a consumer in another community. When fares and

tariffs are not sufficient there should be some method of tax-supported transportation assistance. Surely, we can find the ways to give direct or indirect government assistance to bus lines and other modes of transportation to assist our rural elderly. Of course, rail passenger service is almost non-existent. Perhaps some of our rail lines can be revitalized.

Taxation

The tax policy in this country should be designed to encourage private initiative, economic growth, equity and simplicity. We have not seen that. A number of things could be done to our tax code to simplify and to encourage growth, to encourage capital formation for use in our later years. We would support revisions in the federal tax code to provide income tax averaging. That is vital in agriculture when our income certainly has its ups and downs.

We would support a provision to allow self-employed taxpayers to deduct the full cost of their health insurance premiums.

We encourage Congress to reinstate capital gains treatment. When someone has acquired a capital good and for any reason must sell, the treatment of any capital gain as ordinary income is punitive.

We support an exemption from social security taxes for that portion of a self-employed persons income that is attributable to return on investment.

One of the things you as a Committee could do, could recommend to your colleagues in the Congress, that would assist

the rural elderly and all other citizens, would be to provide for - **insist on and help develop** - a BALANCED BUDGET. We cannot continue sapping the resources of the citizens of this country to pay for future generations. We need to balance the federal budget. We can do that and still provide the necessary services for citizens of all ages.

We certainly thank you again for conducting this Field Hearing in Pittsburg, Kansas. We invite your careful attention to those items we have highlighted, just a few of the things which we believe would be of assistance to our rural elderly, and would allow them to continue as productive citizens in the rural communities of this state and the Nation.

TESTIMONY

BEFORE

THE SELECT COMMITTEE ON AGING

FIELD HEARING

AT PITTSBURG, KANSAS

"MENTAL HEALTH ISSUES
OF
THE RURAL AGING"

Presented by:

H. Ivor Jones, M.D.

Shawnee Mission, Kansas

Monday, June 13, 1988

My name is H. Ivor Jones, M.D. from Shawnee Mission, Kansas. At one time I was Director of the Johnson County Mental Health Center and I am currently in the private practice of psychiatry.

I am also a former president of the Kansas Psychiatric Society.

I am pleased that you asked me to give Testimony before this HOUSE SELECT COMMITTEE ON AGING and note that you particularly want:

1. a brief overview of the mental health issues facing the elderly.
2. What are the problems of access to mental health services of the elderly living in rural areas.
3. innovative solutions to these problems.

1. OVERVIEW

The elderly, wherever they may live, share the common problems of growing older, yet those living in rural areas report a more difficult time coping with these problems than do their urban counterparts. Large distances and low population

densities compound the difficulties of low retirement income, lack of transportation, inadequate medical care, little or no medical insurance coverage, ignorance about facilities and services where such is available and poor housing.

All these factors are being addressed and considered in this hearing and, indeed, in most cases several factors are operative such that where excellent care can be rendered in one area only to be undermined by another factor--for example: good care at a clinic but living on a marginal diet and not having funds to fill a prescription.

Where there is economic distress there is a snowball effect: many elderly have seen their life's work plummet with the depressed farm economy--farm foreclosures cause financial difficulties in the locality's banks, lending institutions, and small businesses--a loss of personal income and reduced tax base--then reduced local health services, partial or complete closure of rural hospitals and a disruption of social service programs--and turnover and loss of health service personnel. Tough choices have to be made: many forego much needed medical care--they go without insurance--put off seeing the doctor--many go without necessary care because they cannot afford services not covered by Medicare. For example: a $600.00 hearing aid is not covered by Medicare--these people become more and more isolated with poverty, depression and deafness, yet each factor is "treatable".

Another facet we must address:

> "You won't get a farmer to come into a mental health center and fill out forms. Their problems are always understated and mental health professionals have not realized how understated they are so they believed there isn't a problem-----We have to change our way of thinking."
> (Joan Blundell-Iowa)

The independence and stoicism that enabled farmers--and the farm community to survive off the land are now liabilities when it comes to recognizing their need for, and asking for help.

---We have to change--that is, we the care givers need to learn to develop coordinated, cooperative programs tailored to special needs.

If a psychiatrist can't be flexible, why should he expect his patient to be able to learn new ways of coping?

There are numerous studies including one from Kansas State University that find between 12 and 23 percent of a mostly rural elderly population showed significant psychiatric symptoms. However, only one percent of the frail elderly population studied had sought mental health services. Many also had physical as well as emotional problems and felt isolated from family and friends.

A University of Missouri study found all the women and most of the men in families forced out of farming by finances

were depressed during their financial difficulties. Half the men and three-quarters of the women continued to be depressed after some financial settlement was reached. This study noted increased alcoholism, substance abuse, emotional withdrawal and physical abuse.

Of related interest, studies at U.C.L.A. and in New York, showed twice the number of rural adolescents were moderately or severely depressed compared with city youth.

2. ACCESS TO CARE

Other witnesses will elaborate on:

a. lack of transportation, long distances.

b. Lack of awareness of services.

c. No insurance or inadequacy of insurance coverage.

d. Reluctance to use "welfare" or public services even if they are available.

e. Lack of basic services as well as paucity of specialist services.

f. Our medical schools do not do a good job preparing a physician or nurse to deliver health care in rural settings. This also applies to geriatrics. Many physicians do not know how to cope with the older patient who is frightened or hard of hearing. They also need to become sensitized to the often unspoken needs of the ~~the~~ older patient.

g. County Public Health Departments might consider a traveling health van to do screenings and assessments. If they don't come to us, then we go to them. Specialists could participate on a rotating basis by attending clinics set up at existing senior citizens' centers on a scheduled basis.

h. Assist communities to train local people in rural areas to provide home care and respite care. ("Neighbor helping neighbor"--"a rural job-bank")

i. The endangered rural hospitals with low occupancy rates will need help to be innovative and flexible. Should they house the County Health Department, the Community Mental Health Center and, yes, even the local drivers license bureau so people waiting for service can become informed of their community health services? All services need visibility.

3. SEEKING INNOVATIVE SOLUTIONS

In 1963 when I became Director of the Johnson County Mental Health Center we had a very limited budget. In meetings with our County Commissioners I found that they expected me to function somewhat in the traditional psychiatrist's role--seeing patients in the office for the usual one hour. With 3 professionals we could never hope to meet the needs of the community.

I started building a network of "other care-givers", meeting with them regularly on a weekly basis:

a. Public Health Nurses 8

b. Social Service Workers 5-8 usually

c.	Juvenile Probation Staff	6
d.	School Nurses	22
e.	School Counselors	14
	Total: over	55

So within a few months the Mental Health Center staff of 3 had grown to a network of over 55 additional case workers WITHOUT ADDITIONAL BUDGET but with a wealth of creative, innovative, enthusiastic 'part-time' staff members.

Emphasis was given to learning to recognize stress in adults and children, case finding and evaluation of families in distress. Each member extended the effectiveness of their own job.

I urged these professionals to not only keep records of the many valuable services they rendered, but more importantly, to keep good records of the services that they recognized as ~~having~~ being needed but which they could not provide. Thus over the course of several years they had facts and figures to back-up their own budget requests for more personnel and training.

The Mental Health Center grew in many ways but most importantly in recognizing that many problem families or individual situations were multi-factorial, that is, there were many problems, many causations requiring much coordination

of services to achieve solutions.

During this period (1963-67) the Mental Health Center felt it had a role to play in caring for the patient returning to the Community after a stay at the State Mental Hospital. The Cooperative Aftercare Project (CAP) had its beginning.

The Mental Health Center had monthly meetings of representatives from:

a. The State Hospital (Social Service)
b. Social Welfare Department (County)
c. Public Health Nurses (County)
d. A minister representing the Ministerial Alliance.
e. Mental Health Association
f. Vocational Rehabilitation (Job Training)
g. State Employment Service.

They came prepared to discuss what they could offer in such a case as:

"Mr. AB, 54 year-old became an alcoholic and lost his job (printer) during the lengthy terminal illness of his wife. He became profoundly depressed when she died, and became further behind in his rent. As he was uninsured he was sent to the State Hospital for care and treatment."

We are now told he will be ready soon to return to

our community. What services does he need, what can we offer him?

What was so different about CAP was that the different agencies counted themselves in by offering a constellation of services; a case coordinator was designated as a case manager. Each agency learned a great deal about the resources and skills and personalities of their sister agencies and did NOT feel overwhelmed with the sole reponsibility for a difficult case.

We requested and received funding from United Way for a social worker coordinator for our Cooperative Aftercare Project (CAP).

The patients, their families, the community and the several agencies all benefited from this CAP which did NOT require extensive funding--just a new way of working together.

I believe that CAP can serve as a model for: --

Cooperative AGING Projects

Cooperative ALCOHOLISM Projects

Cooperative ADDICTION Projects

Cooperative ADOLESCENT Projects

Cooperative AIDS Projects

Designing a project for the Rural elderly I would like to see what could be done involving the traditional agencies but adding representatives from:

Agricultural Extension Service

Grange

Young Farmers Organizations

Focused Volunteer programs from our Civic Groups and PTA

Look to newspapers, radio and TV for Public Service Announcements stressing that we are indeed our brother's keeper.

Federal, State and County Tax moneys certainly should be considered but realistically I know it is unlikely to be forthcoming in impoverished rural areas,

therefore

it is incumbent on us to develop innovative, creative and cooperative programs to meet the special mental, physical, social and health needs of the rural elderly.

P.S. Keep a record of the needed services you can't provide, eventually with cross-fertilization of ideas and help from others you will create new solutions--different but none-the-less effective answers.

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